THE LACK OF HOSPITAL EMERGENCY SURGE CAPACITY: WILL THE ADMINISTRATION'S MEDICAID REGULATIONS MAKE IT WORSE?

HEARINGS

BEFORE THE

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

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THE LACK OF HOSPITAL EMERGENCY SURGE CAPACITY: WILL THE ADMINISTRATION'S MEDICAID REGULATIONS MAKE IT WORSE? DAY ONE

MONDAY, MAY 5, 2008

HOUSE OF REPRESENTATIVES,
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
Washington, DC.

The committee met, pursuant to notice, at 10 a.m., in room 2154, Rayburn House Office Building, Hon. Henry A. Waxman (chairman of the committee) presiding.

Present: Representatives Waxman, Watson, Norton, Shays, Issa, and Bilbray.

Staff present: Phil Barnett, staff director and chief counsel; Karen Lightfoot, communications director and senior policy advisor; Andy Schneider, chief health counsel; Sarah Despres, senior health counsel; Steve Cha, professional staff member; Earley Green, chief clerk; Carren Audhman and Ella Hoffman, press assistants; Leneal Scott, information systems manager; Kerry Gutknecht and William Ragland, staff assistants; Larry Halloran, minority staff director; Jennifer Safavian, minority chief counsel for oversight and investigations; Christopher Bright, Jill Schmaltz, Benjamin Chance, and Todd Greenwood, minority professional staff members; John Cuaderes, minority senior investigator and policy advisor; and Ali Ahmad, minority deputy press secretary.

Chairman WAXMAN. The meeting of the committee will please come to order. Today we're holding the first of 2 days of hearings on the impact of the administration's Medicaid regulations on hospital emergency surge capacity and the ability of hospital emergency rooms to respond to a sudden influx of casualties from a terrorist attack.

The committee held a hearing in June 2007 on the Nation's emergency care crisis. We heard from emergency care physicians that America's emergency departments are already operating over capacity. We were warned that if the Nation does not address the chronic overcrowding of emergency rooms their ability to respond to a public health disaster or terrorist attack will be severely jeopardized.

The Department of Health and Human Services was represented at that hearing, but despite the warnings the Department has issued three Medicaid regulations that will reduce Federal funds to public and teaching hospitals by tens of billions of dollars over the next 5 years. The committee held a hearing on these and other

Medicaid regulations in November 2007. An emergency room physician told us that if these regulations are allowed to go into effect, the Nation's emergency rooms will take a devastating financial hit.

The two hearings that we will be holding this week will focus on the impact of these Medicaid regulations on our capacity to respond to the most likely terrorist attack, one using bombs or other conventional explosives.

Today we will be hearing from an independent expert on terrorism, an emergency room physician, a trauma surgeon, a nurse with expertise in emergency preparedness, and a State official responsible for planning for disasters like a terrorist attack.

On Wednesday, we'll hear testimony from the two Federal officials with lead responsibility for Homeland Security and for Medicaid, the Secretary of Homeland Security, Michael Chertoff, and the Secretary of Health and Human Services, Michael Leavitt.

In preparation for this hearing the committee majority staff conducted a survey of emergency room capacity in five cities considered at greatest risk of a terrific attack, Washington, DC, New York, Los Angeles, Chicago and Houston, as well as Denver and Minneapolis, where the nominating conventions will be held later this year. The survey took place on Tuesday, March 25th at 4:30 p.m. Thirty-four Level 1 trauma centers participated in the survey.

What the survey found was truly alarming. The 34 hospitals surveyed did not have sufficient ER capacity to treat a sudden influx of victims from a terrorist bombing. The hospitals had virtually no free intensive care unit beds to treat the most seriously injured casualties. The hospitals did not have enough regular inpatient beds to handle the less seriously injured victims.

The situation in Washington, DC, and Los Angeles was particularly dire. There was no available space in the emergency rooms at the main trauma centers serving Washington, DC. One emergency room was operating at over 200 percent of capacity. More than half the patients receiving emergency care in the hospital had been diverted to hallways and waiting rooms for treatment.

And in Los Angeles three of the five Level 1 trauma centers were so overcrowded that they went on diversion, which means they closed their doors to new patients. If a terrorist attack had occurred in Washington, DC, or Los Angeles on March 25th when we did our survey, the consequences could have been catastrophic. The emergency care systems were stretched to the breaking point and had no capacity to respond to a surge of victims.

Our investigation has also revealed what appears to be a complete breakdown in communications between the Department of Homeland Security and the Department of Health and Human Services.

In October 2007, the President issued Homeland Security Directive No. 21. The directive requires the Secretary of HHS to identify any regulatory barriers to public health and medical preparedness that can be eliminated by appropriate regulatory action. It also requires the Secretary of HHS to coordinate with the Secretary of DHS to ensure we maintain a robust capacity to provide emergency care. Yet when the committee requested documents reflecting an analysis of the potential implications of the Medicaid regulations

on hospital emergency surge capacity, neither department was able to produce a single document.

This is incomprehensible. It appears that Secretary Leavitt signed regulations that will take hundreds and millions of dollars away from hospital emergency rooms without once considering the impact on national preparedness. And it appears that Secretary Chertoff never raised a single objection.

The Department of Health and Human Services was represented at the committee's June 2007 hearing on emergency care crisis. The importance of adequate Federal funding for emergency and trauma care was repeatedly stressed by the expert witnesses at the hearing. If Secretary Leavitt approves the Medicaid regulations without considering their impact on preparedness and without consulting with Secretary Chertoff, that would be a shocking and inexplicable breach of responsibilities.

The most damaging of the administration's Medicaid regulations will go into affect on May 26th, just 3 weeks from today. As the House voted overwhelmingly, the regulation should be stopped until their true impacts can be understood. I don't know whether the House legislation will pass the Senate or, if it does, whether the bill will survive a threatened Presidential veto. But I do know that Secretary Leavitt and Secretary Chertoff have the power to stop these destructive regulations from going into effect. And I intend to ask them whether they will use their authority to protect hospital emergency rooms.

The Federal Government has poured billions of dollars into homeland security since the 9/11 attack. As investigations by this committee have documented, much of this investment was squandered on boondoggle contracts. This was evident after Hurricane Katrina when our capacity to respond fell tragically short.

The question we will be exploring today and on Wednesday is whether a key component of our national response hospital emergency rooms will be ready when the next disaster strikes.

I want to recognize Mr. Shays. He is acting as the ranking Republican for today.

[The prepared statement of Chairman Henry A. Waxman follows:]

Opening Statement of Rep. Henry A. Waxman
Chairman, Committee on Oversight and Government Reform
The Lack of Hospital Emergency Surge Capacity: Will the Administration's Medicaid Regulations Make It Worse?
Day One
May 5, 2008

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Mr. SHAYS. Thank you, Mr. Chairman. I appreciate, Chairman Waxman, your calling today's hearing to review the relationship between emergency medical surge capacity and Medicaid reimbursement policies. The sad reality we must contend with every day is the need to be ready for that one horrible day when terrorism sends mass casualties to an already overburdened medical system.

Medicaid reimbursement policies may need to change to better support large urban emergency and trauma centers, but those changes alone will never assure adequatesurge capacity. We cannot afford to build and maintain idle trauma facilities waiting for the tragic day we pray never comes when they will be needed.

In 2004, 10 terrorist bombs exploded simultaneously on commuter trains in Madrid, Spain, killing 177 people and injuring more than 2000. The nearest hospital had to absorb and care for almost 300 patients in a very short time.

In the event of a similar attack here our hospitals will be tasked with saving the greatest number of lives while confronting a large surge of patients and coping with the wave of the worried well. Many will arrive suffering injuries not typically seen in emergency departments. Medical staff will be facing the crisis with imperfect information about the causes and scope of the event and under severe emotional stress. To reduce the stress and treat mass casualties effectively decisions need to be made, resources allocated, and communication established now, not during the unexpected but perhaps inevitable catastrophic event.

Today's hearing is intended to focus on a single aspect of emergency preparedness, Federal reimbursement policies and their implications for Level 1 trauma centers in major metropolitan areas.

I appreciate Chairman Waxman's perspective on the administration's proposed Medicaid regulation changes and join him in voting for a moratorium on their implementation. But I am concerned that a narrow focus on just one component of medical preparedness risks oversimplifying the far more complex realities the health system will face when confronting a catastrophic event.

Stabilizing Medicaid payment policies alone won't guarantee readiness against bombs or epidemics any more than an annual cost to assure people they're safe against inflation or recession. It is a factor to be sure, but not the sole or even the determinative element to worry about when disaster strikes.

We should not miss this opportunity to address the full range of interrelated issues that must be woven together to build and maintain a prepared health system. That being said, there is no question emergency departments are overcrowded, often are understaffed and operating with strained resources on a day-to-day basis. Ambulances are often diverted to distant hospitals and patients are parked in substandard areas while waiting for an inpatient bed.

In 2006, the Institutes of Medicine [IOM], found few financial incentives for hospitals to address emergency room overcrowding. Admissions from emergency departments are often the lowest priority because patients from other areas of the hospital generate more revenue. This is not to disparage hospitals. They operate on tight margins and must navigate challenging, often perverse financial incentives, including Federal reimbursement standards. Strong management, regional cooperation and greater hospital efficiencies offer

some hope for alleviating the strain on emergency departments, but during a catastrophic event bringing so-called surge capacity online involves very different elements.

In a mass casualty response regional capacity is more important than any single hospital capability. Hospitals that normally compete with each other need to be prepared to share information about resources and personnel. They need to agree beforehand to cancel elective surgeries, move noncritical patients and expand beyond the daily triage and intake rates.

Unlike daily operations, surge and emergency response requires interoperable and backup communication systems, interoperable and backup communication systems, altered standards of care, unique legal liability determinations and transportation logistics. Should regional resources or capacity prove inadequate, State assets will be brought to bear. Available beds and patients will need to be tracked in realtime so resources can be efficiently and effectively matched with urgent needs. Civilian and even military transportation systems will have to be coordinated. If needed, Federal resources and mobile units will be integrated into the ongoing response. All of these levels and systems have to fall into place in a short time during a chaotic situation.

So it is clear daily emergency department operations are at best an indirect and imperfect predictor of emergency response capabilities. The better approach is for local, State and the Federal Governments to plan for mass casualty scenarios and exercise those plans. That way specific gaps can be identified and funding can be targeted to address disconnects and dysfunctions in the regional response. Fluctuating per capita Medicaid payments probably will not and often cannot be used to fund those larger structural elements of surge capacity.

Today's hearing can be an opportunity to evaluate all the elements of emergency medical preparedness. We value the expertise our witnesses bring to this important discussion, and we look forward to their testimony.

[The prepared statement of Hon. Christopher Shays follows:]

HENRY A. WAXMAN, CALIFORNIA
CHAIRMAN

TOM DAVIS, VIRGINIA
RANKING MINORITY MEMBER

ONE HUNDRED TENTH CONGRESS

Congress of the United States

House of Representatives

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Statement of Rep. Christopher Shays
Committee on Oversight and Government Reform
"The Lack of Hospital Emergency Surge Capacity: Will the Administration's Medicaid Regulations Make it Worse?"
May 5, 2008

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In 2004, ten terrorist bombs exploded simultaneously on commuter trains in Madrid, Spain, killing 177 people instantly and injuring more than 2000. The nearest hospital had to absorb and care for almost 300 patients in a very short time. In the event of a similar attack here, our hospitals will be tasked with saving the greatest number of lives while confronting a large surge of patients and coping with a wave of the "worried well." Many will arrive suffering injuries not typically seen in emergency departments. Medical staff will be facing the crisis with imperfect information about the causes and scope of the event and under severe emotional stress. To reduce that stress and treat mass casualties effectively, decisions need to be made, resources allocated, and communication established now, not during the unexpected, but perhaps inevitable, catastrophic event.

Today's hearing is intended to focus on a single aspect of emergency preparedness: federal reimbursement policies and their implications for Level 1 trauma centers in major metropolitan areas. I appreciate Chairman Waxman's perspective on the Administration's proposed Medicaid regulation changes and joined him in voting for a moratorium on their implementation.

But I am concerned that a narrow focus on just one component of medical preparedness risks oversimplifying the far more complex realities the health system will face when confronting a catastrophic event. Stabilizing Medicaid payment policies alone won't guarantee readiness against bombs or pandemics any more than annual cost of living raises

assure people they're safe against inflation or a recession. It's a factor, to be sure, but not the sole, or even the determinative, element to worry about when disaster strikes. We should not miss this opportunity to address the full range of interrelated issues that must be woven together to build and maintain a prepared health system.

That being said, there is no question that emergency departments are overcrowded, often understaffed, and operating with strained resources. On a day-to-day basis ambulances are often diverted to distant hospitals and patients are parked in substandard areas while waiting for an inpatient bed. In the 2006, the Institutes of Medicine (IOM) found few financial incentives for hospitals to address emergency room overcrowding. Admissions from emergency departments are often the lowest priority because patients from other areas of the hospital generate more revenue. This is not to disparage hospitals. They operate on tight margins, and must navigate challenging, often perverse, financial incentives - including federal reimbursement standards. Strong management, regional cooperation and greater hospital efficiencies offer some hope for alleviating the strain on emergency departments.

But during a catastrophic event, bringing so-called "surge capacity" on-line involves very different elements. In a mass casualty response, regional capacity is more important than any single hospital's capability. Hospitals that normally compete with each other need to be prepared to share information about resources and personnel. They need to agree beforehand to cancel elective surgeries, move non-critical patients and expand beyond daily triage and intake rates. Unlike daily operations, surging emergency response requires interoperable and back-up communication systems, altered standards of care, unique legal liability determinations, and transportation logistics.

Should regional resources or capacity prove inadequate, state assets will be brought to bear. Available beds and patients will need to be tracked in real time so resources can be efficiently and effectively matched with urgent needs. Civilian and even military transportation systems will have to be coordinated. If needed, federal resources and mobile units will be integrated into the ongoing response. All of these levels and systems have to fall into place in a short time and during a chaotic situation.

So it's clear daily emergency department operations are, at best, an indirect and imperfect predictor of emergency response capabilities. The better approach is for local, state, and the federal governments to plan for mass casualty scenarios and exercise those plans. That way, specific gaps can be identified and funding can be targeted to address disconnects and dysfunctions in the regional response. Fluctuating, per-capita Medicaid payments probably will not – and often cannot – be used to fund those larger, structural elements of surge capacity.

Today's hearing can be an opportunity to evaluate all the elements of emergency medical preparedness. We value the expertise these witnesses bring to this important discussion and we look forward to their testimony.

Chairman WAXMAN. Thank you very much. Mr. Shays.

While the rules provide for just the chairman and the ranking member to give opening statements, I do want to give an opportunity for the two other Members that are with us to make any comments they wish to make.

Ms. Watson.

Ms. WATSON. Thank you very much, Mr. Chairman the Los Angeles County board of supervisors visited Capitol Hill last week. And the No. 1 theme that continued to surface in my conversations with many of the supervisors was the widening gap between the demand for Medicare/Medicaid assistance and the administration's new regulations that will limit the amount of Medicaid/Medicare reimbursement to the State.

The administration estimates that the total fiscal impact of the regulatory changes of $15 billion, but a committee report, based on States that responded to the committee's request for information, concludes that the change in regulations would reduce Federal payments to States by $49.7 billion over the next 5 years. The cost to California alone is estimated to be $10.8 billion over 5 years.

Mr. Chairman, as you well know, in the case of California the reductions and Federal funding would destabilize an already fragile medical care delivery service for low income residents and the uninsured. The impact of these changes will be far reaching and potentially catastrophic. In the last year we have witnessed the closing of many of King/Drew's hospital medical facilities located in Watts, CA. The emergency care facility has been closed now for some time. The impact of this closing is that residents from this underserved area of Los Angeles are transported to other areas of town and the critical minutes that are needed to administer care to save lives are now lost.

The impact of King/Drew closing has had a cascading effect on all the other area hospitals, including those outside of the Los Angeles area, that now must pick up the slack. I cannot imagine what would happen in these areas in the case of a mass catastrophic event such as a terrorist attack using conventional explosives or a natural disaster since they are already suffering from a lack of adequate emergency medical care facilities.

So I look forward to the testimony from today's witnesses who are experts in medicine and medical delivery services and counterterrorism. Again, thank you, Mr. Chairman, for holding this hearing.

Chairman WAXMAN. Thank you, Ms. Watson.

Mr. Issa.

Mr. ISSA. Thank you, Mr. Chairman, for holding this hearing.

Mr. Chairman, I'm troubled with today's hearing for one reason. I think there's a legitimate problem, overcrowding of our emergency rooms. That overcrowding comes from a combination of illegal immigration, legal immigration and a pattern of going to emergency rooms when in fact urgent care would be a better alternative. I think it is part of a bigger problem we particularly in California face that we have in fact a large amount of uninsured. But they are not insured, they are insured at the emergency room. That overcrowding needs to be dealt with.

And I trust that on a bipartisan basis in good time we will deal with the challenges created by illegal immigration, individuals who either because of that or because they lack insurance are choosing the emergency room over more effective and efficient delivery systems.

Having said that, I particularly am concerned that a partisan amateur survey was done in order to justify or politicize today's hearing. It's very clear both by the ranking member's opening statement and by the facts that we will clearly see here today that a survey of emergency rooms done by Democrat staff for the purpose of getting the answer they wanted, which was of course we're overcrowded at the emergency room, is self-serving and unfortunately short-sighted.

The number of beds that could be made available in a hospital, the number of health care professionals, doctors, nurses and the like that could be brought to bear within a period of time would have been part of any effective analysis of what the surge capacity could be, the number of patients who, although in the hospital, could be removed to other facilities of lesser capability to make room for severely injured people.

Although this would not change the fact that if we had a Madrid type occurrence, even in a city like Los Angeles, 2000 severely injured people would strain our capacity in the first few hours. And undoubtedly, undoubtedly, just like a 200-car pileup on the 405, we would have loss of life that we would have not have in a lesser occurrence.

I do believe that the challenges of Medicare and Medicaid in dealing with escalating costs, and particularly for California the cost of reimbursement which has not been sufficient, needs to be looked at. I hope that we can work on a bipartisan basis to deal with these problems. I hope that today's hearings will in fact cause us all to understand the causes and the cures for overcrowding of our emergency rooms.

However, I must reiterate that the Federal response for this type of emergency needs to be to pay to train and to pay to test for these kinds of emergencies. That's the appropriate area for the Federal Government to deal with in addition to providing certain life saving resources such as mass antibiotics like Cipro and of course also smallpox and other vaccinations in case of an attack.

These are the Federal responses that were agreed to after 9/11 on a bipartisan basis, and I would trust that at a minimum we would not allow an issue such as how much is reimbursed to California on a day-to-day basis to get in the way of making sure that we fully fund those items which would not and could not be funded locally or by States.

Mr. Chairman, I look forward to today's hearing. You have a distinguished panel that I believe can do a great deal to have us understand the problem. With that, I yield back.

Chairman WAXMAN. Our witnesses today do amount to a very distinguished panel and we're looking forward to hearing from them. Dr. Bruce Hoffman is professor of the Edmund A. Walsh School of Foreign Service at Georgetown University here to discuss mass casually events involving conventional explosives in general and suicide terrorism in particular. He will also discuss his re-

search on the Australian, British and Israeli responses to these types of terrorist attacks.

Dr. Wayne Meredith is a professor and chairman of the Department of General Surgery at Wake Forest University Baptist Medical Center. In his role as a trauma surgeon Dr. Meredith will discuss the clinical importance of immediate response to trauma such as that resulting from a blast attack as well as the importance of adequate financing to maintain a coordinated trauma care system.

Dr. Colleen Conway-Welch is the dean of the School of Nursing at Vanderbilt University. She'll discuss the implications of the Medicaid regulations for hospital emergency and trauma care capacity, including whether States or localities will be able to hold hospitals harmless against the loss of Federal funds that will result from the regulations.

Dr. Roger Lewis is an attending physician and professor in the Department of Emergency Medicine at Harbor-UCLA Medical Center. He will discuss the connections between emergency department crowding, surge capacity and disaster preparedness. He will also discuss the impact of the Medicaid regulations on his hospital, which participated in the majority staff snapshot survey.

Dr. Lisa Kaplowitz is the deputy commissioner for emergency preparedness and response at the Virginia Department of Health. She will present the State perspective on emergency preparedness in response to mass casualty events, including the lessons learned from the Virginia Tech shootings.

We're pleased to have you all here today. We welcome you to our hearing. It's the policy of this committee that all witnesses that testify before us do so under oath. So if you would please rise and raise your right hands, I would appreciate it.

[Witnesses sworn.]

Chairman WAXMAN. The record will indicate that each of the witnesses answered in the affirmative. Your prepared statements will be made part of the record in full. What we'd like to ask you to do is to acknowledge the fact that there's a clock that will be running, indicating 5 minutes. For the first 4 minutes it will be green, for the last minute will be orange, and then when the time is up it will be red. And when you see the red light we would appreciate it if you would try to conclude your oral presentation to us. If you need another minute or so and it is important to get the points across, we're not going to be so rigid about it, but this is some way of trying to keep some time period that's fair to everybody.

Dr. Hoffman, let's start with you. There's a button on the base of the mic, we'd like to hear what you have to say.

STATEMENTS OF BRUCE HOFFMAN, PH.D., PROFESSOR, EDMUND A. WALSH SCHOOL OF FOREIGN SERVICE, SECURITY STUDIES PROGRAM, GEORGETOWN UNIVERSITY; JAY WAYNE MEREDITH, M.D., PROFESSOR AND CHAIRMAN, DEPARTMENT OF GENERAL SURGERY, WAKE FOREST UNIVERSITY BAPTIST MEDICAL CENTER; COLLEEN CONWAY-WELCH, PH.D., DEAN, VANDERBILT SCHOOL OF NURSING; ROGER LEWIS, M.D., PH.D., DEPARTMENT OF EMERGENCY MEDICINE, HARBOR-UCLA MEDICAL CENTER; AND LISA KAPLOWITZ, M.D., DEPUTY COMMISSION FOR EMERGENCY PREPAREDNESS AND RESPONSE, VIRGINIA DEPARTMENT OF HEALTH

STATEMENT OF BRUCE HOFFMAN, PH.D.

Mr. HOFFMAN. Thank you, Mr. Chairman, for the opportunity to testify before this committee on this important issue. As a counterterrorism specialist and a Ph.D., not an M.D., let me share with the committee my impressions of the unique challenges conventional terrorist bombings and suicide attacks present.

This is not a place to have a wristwatch, Dr. Shmuel "Shmulik" Shapira observed as we looked at x-rays of suicide bombing victims in his office in Jerusalem's Hadassah Ein Kerem Hospital nearly 6 years ago. The presence of such foreign objects in the bodies of his patients no longer surprised Dr. Shapira, a pioneering figure in the field called terror medicine. We had cases with a nail in the neck or nuts and bolts in the thigh, a ball bearing in the skull, he recounted. Such are the weapons of terrorists today, nuts and bolts, screws and ball bearings or any metal shards or odd bits of broken machinery that can be packed together with enough homemade explosive or military ordnance and then strapped to the body of a suicide terrorist dispatched to attack any place people gather.

According to one estimate, the total cost of a typical Palestinian suicide operation, for example, is about $150. Yet for this—yet this modest sum yields a very attractive return. On average suicide operations worldwide kill about four times as many persons as other kinds of terrorist attacks. In Israel the average is even higher, inflicting six times the number of deaths and roughly 26 times the number of casualties than other acts of terrorism.

Despite the potential array of atypical medical contingencies that the U.S. health system could face if confronted with mass casualty events [MCE], resulting from terrorist attacks using conventional explosives, it is not clear that we are sufficiently prepared. Historically the bias and most MCE planning has been toward the worst case scenarios, often containing weapons of mass destruction, such as chemical, biological, radiological and nuclear weapons, on the assumption that any other MCEs, including those where conventional explosions are used, could simply be addressed as a lesser included contingency.

By contrast, Israeli surgeons have found that the metal debris and other anti-personnel matter packed around the explosive charge causes injury to victims, victims that are completely atypical of other emergency traumas in severity, complexity and number.

Unlike gunshot wounds from high velocity bullets that generally pass through the victim, for instance, these secondary fragments remain lodged in the victim's body. Indeed, although much is known about the ballistic characteristics of high velocity bullets and shrapnel used in military ordnance, very little research has yet to be done on the ballistic properties of the improvised and anti-personnel materials used in terrorist bombs.

The over pressure caused by the explosion is especially damaging to the air filled organs of one's body. For this reason the greatest risk of injury are to the lungs, gastrointestinal tract and auditory system. The lungs are the most sensitive organ. And ascertaining the extent of damage can be particularly challenging given that signs of respiratory failure may not appear until up to 24 hours after the explosion.

And over 40 percent of victims injured by secondary fragments from bombs suffer multiple wounds in different places of their body. By comparison fewer than 10 percent of gunshot victims typically are wounded in more than one place on their body. A single victim may thus be affected in a variety of radically different ways.

In addition, severe burn injuries may have been sustained by victims on top of all the above trauma. Thus critical injuries account for 25 percent of terrorist victims in Israel overall compared with 3 percent with nonterrorism-related injuries.

Australia's principal experiences with terrorist MCEs has primarily been as a result of the October 2002 bombings in Bali, Indonesia, where 91 Australian citizens were killed and 66 injured. The survivors were air lifted to Darwin where the vast majority were treated at the Royal Darwin Hospital.

Forty-five percent of these survivors were suffering from major trauma and all had severe burns. The large number of burn victims presented a special challenge to the Royal Darwin Hospital, as indeed no one hospital in the entirety of Australia had the capacity or capabilities to manage that many blast and burn victims. Accordingly, the Australian medical authorities decided to move them to other hospitals across Australia.

London's emergency preparedness and response in the event of terrorist MCEs had been based on New York City's experience with the 9/11 attacks. However, the suicide bombings of the three subway cars and bus on July 7, 2005 was a significantly different medical challenge.

In New York City on 9/11 many persons died and only a few survived. The opposite occurred on July 7th when only a small proportion of victims lost their lives, 52 persons tragically, but more than 10 times that number were injured. London's long experience with Irish terrorism, coupled with extensive planning, drills and other exercises ensured that the city's emergency services responded quickly and effectively in a highly coordinated manner. But even London's well-honed response to the MCE on July 7, 2005 was not without problems. For example, communications between first responders with hospitals or their control rooms were not as good as they should have been, which resulted in uneven and inappropriate distribution of casualties among area hospitals.

What emerges from this discussion the medical communities emergency response and preparedness for terrorist MCEs involving

conventional explosions and suicide attacks are two main points: First, that there are lessons we can learn from other countries' experiences with terrorist bombings and suicide attacks that would significantly improve and speed our recovery should terrorists strike here. Israel, Australian, Britain and others are highly relevant examples.

The second is that the best way to save as many lives as possible after a terrorist bombing or suicide attack is for physicians and other health care workers to undergo intensive training and preparation before an attack, including staging drills at hospitals to cope with sudden overflow of victims with a variety of injuries from terrorist attacks.

Medical professionals and first responders must also understand that the specific demands of responding to bombings and suicide attacks are uniquely challenging. Death and injury may come not only from shrapnel and projectiles, but also from collapsed and pulverized vital organs, horrific burns, seared lungs and internal bleeding.

It is crucial that emergency responders evaluate their response protocols and be prepared for the unusual circumstances created by bomb attacks. Moreover, given the increased financial stress on our Nation's health system in general and urban hospitals in particular, any degradation of our existing capabilities will pose major challenges to our Nation's readiness for attack. Indeed, the opposite is required, a strengthening of our capabilities of hospitals and for the emergency services that we require to effectively respond to a terrorist MCE involving conventional bombing and suicide attacks.

Thank you.

[The prepared statement of Mr. Hoffman follows:]

THE CAPABILITY OF EMERGENCY DEPARTMENTS AND EMERGENCY MEDICAL SYSTEMS IN THE U.S. TO RESPOND TO MASS CASUALTY EVENTS RESULTING FROM TERRORIST ATTACKS

Written Testimony Submitted to
The U.S. House of Representatives Committee on
Oversight and Government Reform,
5 May 2008

Professor Bruce Hoffman
Georgetown University, Washington, D.C.

"This is not a place to have a wristwatch," Dr. Shmuel "Shmulik" Shapira observed as we looked at x-rays of suicide bombing victims in his office at Jerusalem's Hadassah Hospital nearly six years ago. He was describing the injuries to a young girl who had been taking the bus to school one morning in November 2001 when a bomb exploded. Twelve of her fellow passengers were killed and nearly 50 others wounded. The blast was so powerful that the hands and frame of her assailant's wristwatch had turned into lethal projectiles, lodging in the girl's neck and severing a major artery. The presence of such foreign objects in the bodies of his patients no longer surprised Dr. Shapira. "We have cases with a nail in the neck or nuts and bolts in the thigh . . . a ball bearing in the skull," he recounted.

Such are the weapons of terrorists today: nuts and bolts, screws and ball bearings or any metal shards or odd bits of broken machinery that can be packed together with enough home-made explosive or military ordnance and then strapped to the body of a suicide terrorist dispatched to attack any place that people gather: buses and trains, restaurants and cafes, hotels and bars, supermarkets and shopping malls, street corners and promenades. According to one estimate, the total cost of a typical Palestinian suicide operation, for example, is about $150.[1] Yet

[1] Nasra Hassan, "Letter From Gaza: An Arsenal of Believers," *The New Yorker*, 19 November 2001, p. 39.

this modest sum yields a very attractive return: on average, suicide operations worldwide kill about four times as many persons as other kinds of terrorist attacks. In Israel the average is even higher: inflicting six times the number of deaths and roughly 26 times more casualties than other acts of terrorism.[2]

The stress placed on the already over-worked, mostly under-funded, Israeli health system and its hospitals, doctors, nurses, therapists as well as emergency service personnel and first responders in such circumstances is enormous. Whether as a result of a suicide bomb attack or more conventional bombings, these emergencies—as Dr. Shapira notes—present unique medical challenges that to date the United States has mercifully rarely experienced. "Terror demonstrates a new type of epidemiology that is associated with a unique and oddly severe pattern of injuries, putting a heavy burden on society," Dr. Shapira, the deputy director general of Jerusalem's Hadassah Hospitals and a pioneering figure in a new medical specialty that he and others term "terror medicine," explained in a article published five years ago.[3] Indeed, medical studies have shown that the injuries to victims of terrorist bombings are far more severe and complex than those from other traumas.[4] "Bomb explosions," for instance, one medical analysis explains, "cause combinations of burns, barotraumas, and penetrating, blunt crush injuries . . . . Blast victims (especially those with major burns) consume more resources, in volume and time than civilian trauma victims. Treating children and pregnant woman with bomb-blast trauma presents particular challenges."[5]

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[2] The RAND Terrorism Incident Database.

[3] Shmuel C. Shapira and Shlomo Mor-Yosef, "Applying Lessons from Medical Management of Conventional Terror to Responding to Weapons of Mass Destruction Terror: The Experience of a Tertiary University Hospital," *Studies in Conflict & Terrorism*, vol. 26, no. 5 (September-October 2003), p. 385.

[4] Ibid., p. 82. See also, Jeffrey V. Rosenfleld, et al., "Is the Australian hospital system adequately prepared for terrorism?" *eMJA: The Medical Journal of Australia*, vol. 183, nos. 11/12 (2005) accessed at http://www.mja.com.au/public issues/183 11 051205/ros10697 fm.html; and R.G. DePalma, et al., "Blast Injuries," *New England Journal of Medicine*, vol. 352 (2005), pp. 1335-1342 cited in Ibid.

Despite the potential array of atypical medical contingencies that the U.S. health system could face if confronted with mass casualty events (MCE)[6] resulting from terrorist attacks using conventional explosives, it is not clear that we are sufficiently prepared. Historically, the bias in most MCE planning has been towards the worst case scenarios, often entailing weapons of mass destruction (such as chemical, biological, radiological and nuclear weapons), on the assumption that any other MCEs, including those where conventional explosions are used, can simply be addressed as a lesser-included contingency.

This was exactly my concern nearly seven years ago when I testified before a subcommittee of this same committee ten days after the September 11th attacks. At that time, I had identified the need for

> an overarching strategy . . . that ensures that the U.S. is capable of responding across the *entire* technological spectrum of potential adversarial attacks. The focus of U.S. counterterrorism policy in recent years has arguably been too weighted towards the "high end" threats from biological and chemical weapons and was based mainly on planning for extreme worst-case scenarios. This approach seemed to assume that, by focusing on "worst-case" scenarios involving these more exotic weapons, any less serious incident involving a different, even less sophisticated weapon, could be addressed simply by planning for the most catastrophic event. Such an assumption ignored the possibility that these less catastrophic, though

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[5] Rosenfleld, et. Al., "Is the Australian hospital system adequately prepared for terrorism?".

[6] The Israeli medical community defines a mass casualties event as "an incident in which the medical system is overwhelmed and the balance between resources and demands is undermined. Hence, the medical management of MCE presents a formidable challenge to the medical system. The principle aim of the overall medical management of the event is to decrease mortality and morbidity of the entire affected population, even at the cost of providing inferior treatment to the individual patient." See Shmuel C. Shapira and Joshua Shemer, "Medical Management of Terrorist Attacks," *Israeli Medical Association Journal*, vol. 4 (July 2002), p. 489 accessed at http://www.terrormedicine.org/publications_files/medicalmanagement1.pdf. The size of an MCE is defined as small if 8 to 24 are injured; medium if 25 to 59 are injured; and, large if casualties exceed 60 persons. See Jacob Sosna, et al., "Facing the New Threats of Terrorism: Radiologists' Perspectives Based on Experience in Israel," Radiology, vol. 237, no. 1 (October 2005), p. 29 accessed at http://www.terrormedicine.org/publications_files/imaging1.pdf.

> still high casualty incidents, might present unique challenges of their own.[7]

This recommendation was based on my observation that a critical weakness in planning for MCEs before 9/11 may have contributed to that attack's success. U.S. counterterrorism efforts throughout the pre-9/11 time frame, I argued, had been inordinately focused on the more exotic high-end threats posed by biological and chemical weapons as well as cyber-attacks. Of more than 201 federal planning exercises conducted in the United States before 9/11, for example, at least two thirds were concerned only with defending against biological or chemical attacks, and thus ignored the possibility that other kinds of attacks—such as we saw at the World Trade Center and the Pentagon—might result in large numbers of casualties and might present unique challenges of their own in terms of emergency response and rescue.[8]

While I have not followed this issue closely since my 2001 testimony, it is my impression that this situation remains largely unchanged. For instance, a study published by the American Burn Association in 2006 reached the same conclusion I had five years before. "Contemporary planning for disaster response to terrorist events," it stated,

> usually assumes the use of chemical, radiological, or biological weapons. Historically, most victims of terrorist attacks are injured by the use of conventional explosives rather than weapons of mass destruction. Such attacks will likely produce victims who have suffered burn injuries along with conventional trauma . . . .
>
> Unfortunately, exercise planners continually side-step this reality, with most drills focusing on nuclear, biological, or chemical events. In July 2004, the Homeland Security Council released 15 planning scenarios for use in preparedness

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[7] Bruce Hoffman, "Preparing for the War on Terrorism,: Testimony presented to the Subcommittee on National Security, Veterans Affairs, and International Relations, Committee on Government Reform, U.S. House of Representatives 21 September 2001" (Santa Monica, CA: RAND Corp. 2001), p. 7, accessed at http://rand.org/pubs/testimonies/CT181/.

[8] See Joby Warrick and Joe Stephens, "Before Attack, U.S. Expected Different Hit: Chemical, Germ Agents Focus of Preparations," *Washington Post*, 2 October 2001, pp. A1 & A11.

activities. Only one of these scenarios involved the use of uncontaminated explosive material.[9]

The focus of my testimony today, however, is not specifically on either current planning scenarios for MCEs or even specifically on the subject of this hearing: the status of the preparedness and the response capabilities of emergency rooms and trauma centers in the immediate aftermath of a terrorist attack. The former has not been the subject of any recent research I have undertaken; while the latter is beyond my expertise and outside my ken. Rather, what I would like to share with the Committee are the results of my research into the Israeli, Australian and British experiences with these kinds of attacks and the steps that the medical communities in those three countries have taken to minimize loss of life and cope with the unique emergencies created by MCEs caused by terrorists using conventional explosives. And, while the thrust of my remarks will be on the unique demands imposed by suicide bombings—and indeed the constellation of emergency medical preparedness capabilities required in response——my observations and conclusions in this context are equally applicable to MCEs involving more conventional explosive attacks.

THE UNIQUE MEDICAL CHALLENGES CAUSED BY MCES INVOLVING CONVENTIONAL EXPLOSIVES IN GENERAL AND SUICIDE TERRORISM IN PARTICULAR

Suicide terrorism is fast becoming the preferred mode of attack for many terrorist groups throughout the world. Last year, according to the State Department's *Country Reports on Terrorism 2007,* released just last week, the number of suicide attacks worldwide increased by about 50 percent compared with 2006.[10] Indeed, 86 percent of the 1,840 suicide bombings that have occurred since December 1981 have taken place during the past seven years alone. These attacks have now spread to over 30

[9] James Crabtree, "Terrorist Homicide Bombings: A Primer for Preparation," *Journal of Burn Care & Research*, vol. 27, no. 5 (2005), p. 577, accessed at: http://www.terrormedicine.org/publications_files/Terroristbombing.pdf.

[10] "Release of the *Country Reports on Terrorism 2007*, Dell L. Dailey, Coordinator of the Office for Counterterrorism," Russ Travers, Deputy Director of the National Counterterrorism Center; and, Gonzo Gallegos, Director, Office of Press Relations, Washington, D.C., 30, 2008. Accessed at http://www.state.gov/s/ct/rls/rm/2008/104233.htm.

countries on five continents and have killed more than 21,350 person and injured about 50,000.[11]

Accordingly, the suicide bombers who struck the World Trade Center and Pentagon on September 11th 2001 may well be followed by other suicide bombers attacking targets in the United States. Even before 9/11, suicide attacks were either contemplated or planned in the U.S. but thwarted. Timothy McVeigh considered a suicide bomb attack on the Alfred P. Murrah federal office building in Oklahoma City before finding a plan that did not require suicide.[12] Four years before 9/11, two Palestinians plotted a suicide bombing of the New York City subway. Their plan was foiled when an informant tipped off police.[13] And, of course, suicide attacks have now long been conducted against American diplomatic and military targets abroad: from the 1983 bombings of the U.S. embassies and Marine barracks in Beirut to the current campaign of suicide attacks against U.S. troops in Iraq and Afghanistan.

The means of attack using suicide terrorist tactics can vary widely, involving:

- pedestrians—individual attackers wearing a specially-designed vest or belt or carrying a backpack or small hand-held bag containing explosives and connected to a manual or remote-control detonator; or
- vehicular bombs—with a driver and explosive-laden cars or trucks (as in the 1998 simultaneous attacks on the U.S. embassies in Kenya and Tanzania); or
- using either aircraft as human cruise missiles (as in the 9/11 attacks) or boats as human torpedoes (as in the 2000 attack on the *U.S.S. Cole*).

Similarly, the potential targets of these attacks can be equally diverse, embracing:

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[11] See Robin Wright, "Since 2001, a Dramatic Increase in Suicide Bombings," Washington Post, 18 April 2008; and, Bruce Hoffman, Inside Terrorism (New York: Columbia Univ. Press, 2006), p. 131.

[12] Lou Michel and Dan Herbeck, *American Terrorist: Timothy McVeigh & The Oklahoma City Bombing* (New York: Regan, 2001), pp. 102, 144-145, 332, and 358.

- High-value, symbolic targets involving mass casualties against buildings or installations (e.g., the World Trade Center and Pentagon on 9/11); and,
- Deliberately lethal attacks specifically targeting the public (e.g., against buses, trains and subways; shopping malls; cinema; sports stadiums; pedestrian malls or any public venue where people gather) also to inflict mass casualties.

To understand the unique medical challenges posed by MCE involving conventional explosives, it is useful first to understand the mechanics of the suicide terrorist attack.[14] The body bomb worn by a suicide terrorist is typically concealed around the waist or the upper torso. It is often detonated by a simple plunger device or by a toggle or rocker-type switch, running from the bomb to a trouser pocket. A back-up remote control detonation means may also be attached to the bomb enabling a second person to activate the explosive system with a radio signal, cellular phone connection, or beam from a radar gun that completes an electrical circuit. A timing device or igniting of a fuse may also be used. Explosive devices may be carried as well as worn. Backpacks, briefcases, suitcases, duffel bags, gym bags have been used in the past as have guitar and other musical instrument cases, computers, and reportedly even a large watermelon.

The typical explosive device weighs between 10-20 pounds. The standard size suicide jacket or vest worn by Tamil Tiger terrorists in Sri Lanka, for example, is about 18 pounds, containing an even mixture of explosives and ball bearings—the Tamil Tiger's preferred anti-personnel weapon. It is activated by two switches: one standby switch and one triggering switch. The explosives material itself can either be military ordnance (plastic explosive) or homemade explosives such as

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[13] MacNeil/Lehrer Productions, *Transcript of "The News Hour with Jim Lehrer,"* 1 August 1997.

[14] Characteristics drawn from Los Angeles Police Department, "Terrorism Part I: Homicide Bombers," *Training Bulletin*, volume xxxiv, issue 8, September 2002; and, FBI, Bomb Data Center, "Improvised Explosive Devices Used in Suicide Bombing Incidents," *Intelligence Summary 2002-4*, 24 May 2002.

HMTD (Hexamethylene Triperoxide Diamine), a hydrogen peroxide-based mixture that was used by the 7 July 2005 bombers in London, or TATP (Triaceton Triperoxide), an improvised explosive fabricated with nail polish remover among other readily commercially-obtainable ingredients, long favored by Palestinian suicide terrorists targeting Israel. Electronic initiation can be achieved from a simple 1.5-volt (or larger) battery. Fragmentation materials may consist of ball-bearings (as noted above) but also of nails, bolts, or nuts sometimes placed between layers of sheet metal designed to break about into shards of deadly shrapnel. This sandwich-like device is held together until the moment of detonation by tightly bonded glue. Belts containing the explosives and anti-personnel material, because of their thin silhouette and limited capacity, will likely weigh 10 pounds or less and therefore be commensurately less powerful and thus have a smaller blast radius.

Israeli surgeons have found that the metal debris and other anti-personnel matter packed around the explosive charge causes injuries to victims that are completely atypical of other emergency traumas in severity, complexity, and number.[15] This is because the blast generated by suicide bombs and other more conventional explosive devices occurs in milliseconds of time, with tremendous changes caused in ambient pressure, the generation of rapid winds, and a massive heat wave: all of which the victim often perceives as occurring simultaneously.[16] Such an explosion, especially if it occurs within an enclosed area (e.g., a bus or subway car, hotel lobby, restaurant or café) results in an array of injuries that, Israeli doctors note, "is otherwise rarely seen in a single individual: penetration wounds from small projectiles that damage soft tissues and vital organs; fracture bone and sever arteries and nerves; blast effects on lungs, ear drums, and other organs, and severe

[15] Nadav Sheffy, et al., "Terror-Related Injuries: A Comparison of Gunshot Wounds Versus Secondary-Fragments-Induced Injuries from Explosives," *Journal of the American College of Surgeons* (2006), p. 298 accessed at http://www.terrormedicine.org/publications_files/GSWEXP2608.pdf

[16] Crabtree, "Terrorist Homicide Bombings: A Primer for Preparation," p. 579.

burns."[17] Those patients with head or torso injuries, including skull fractures, and with burns to more than 10 percent of the body, are also more likely to have lung injuries.[18] Moreover, unlike gunshot wounds from high-velocity bullets that generally pass through the victim, these secondary fragments remained lodged in the victim's body. Indeed, although much is known about the ballistic characteristics of both high-velocity bullets and the shrapnel used in military ordnance, very little research has yet been done on the ballistic properties of the improvised anti-personnel materials used in terrorist bombs.[19]

The medical profession commonly divides injuries from explosives into three main categories—primary, secondary, and tertiary blast injuries. An article published by four leading Israeli medical specialists in the field explains that

> Primary blast injury occurs as a result of the blast wave-mediated atmospheric pressure change. Secondary damage is caused by missiles and fragments, either embedded inside the explosive device (e.g., bolts, ball bearings, nails) or its casing, or from the shattering effect of the blast on its surroundings (e.g., glass). These secondary missiles are propelled by the blast energy, hitting the patient. Tertiary damage is caused by displacement of the patient's body by the blast wind powerful energy and consequent impact with the ground or surrounding structures.[20]

A fourth category is also used to cover all other injuries caused by the blast: specifically burns; traumas caused by being pinned beneath rubble or crushed by walls, ceilings, retaining columns, vehicles, etc.; and, from the inhalation of toxic particles.[21]

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[17] Shmuel C. Shapira and Leonard A. Cole, "Terror Medicine: Birth of a Discipline," *Journal of Homeland Security and Emergency Management*, vol. 3, issue 2 (2006), article 9 accessed at http://www.terrormedicine.org/publications_files/Terrormedicine

[18] Rosenfeld, et al., "Is the Australian hospital system adequately prepared for terrorism?"

[19] Crabtree, "Terrorist Homicide Bombings: A Primer for Preparation," p. 581.

[20] Sheffy, et al., "Terror-Related Injuries: A Comparison of Gunshot Wounds Versus Secondary-Fragments—Induced Injuries from Explosives," p. 297.

The minute differences in timing and more substantial differences in blast effect and impact accounts for the variety and intensity of injuries.[22] In this respect, it is less important in terms of treatment and diagnosis for medical personnel to know what type of bomb exploded or what kind of ordnance was used than to have information on where exactly the blast occurred. Depending on whether the explosion occurred in an open or confined area will often help medical authorities determine the likely number of injured that will require treatment, the severity of their injuries, and the type of injuries suffered. One study, for example, compared four different bombings—two that occurred within the confined space of a bus and two that occurred in an open environment. It found that the bombs that exploded inside of the two buses had a 49 percent mortality rate compared with just 7.8 percent of fatalities among those injured outdoors. The differences in injuries sustained by the survivors hit with the force of the explosive blast were less dramatic, but still significant: 77.5% of persons inside the buses were injured versus 34 percent of the survivors of the open-air bombings.

Thus it is not surprising that in Israel buses still remain among the bombers' most preferred targets. Winter and summer, in fact, are the favored seasons for suicide bus bombings in Jerusalem. The windows are generally kept closed either to keep in the heat in winter or allow the air conditioning to circulate in summer. In either case, a hermetically enclosed environment is created where the force of the blast is at once contained and intensified: thereby maximizing the a bomb's killing potential. Hence, in addition to the hail of shrapnel piercing flesh and breaking bone, the explosion's shock waves mercilessly tear lungs and bronchi and pulverize internal organs. Burns caused by the fireball unleashed when the bus's fuel tank explodes and the subsequent respiratory damage to the survivors caused by smoke inhalation thus produces for the terrorist a very handsome return for a

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[21] Shapira and Cole, "Terror Medicine: Birth of a Discipline."

[22] Sheffy, et al., "Terror-Related Injuries: A Comparison of Gunshot Wounds Versus Secondary-Fragments-Induced Injuries from Explosives," p. p. 301.

relatively modest investment. For example, two to three kilos of explosive on a bus achieves the same kill ratio as 20 to 30 kilos left on a street or placed in larger, open air spaces such as markets, malls and restaurants. The ease and simplicity of the bus bombing, the concentration of accessible victims and its lethal effectiveness, thus explains its peculiar attraction to terrorists.[23]

The over-pressure caused by the explosion is especially damaging to the air-filled organs of one's body. For this reason, the greatest risk of injury is to the lungs, gastrointestinal tract, and auditory system. The lungs are the most sensitive organ and ascertaining the extent of damage can be particularly challenging given that signs of respiratory failure may not appear until up 24 hours after the explosion. Although damage to hearing is the most common effect of a bomb blast, the heart is also extremely vulnerable "in a manner similar to blunt trauma, with contusions and microscopic injuries predominating."[24] Indeed, over 40 percent of victims injured by secondary fragments suffer multiple wounds in different places of their body. By comparison, fewer than 10 percent of gunshot victims typically are wounded in more than one place on their body. A single victim may thus be affected in a variety of radically different ways.[25] In addition, severe burn injuries may have been sustained by victims in addition to all the above trauma. Finally, traumatic limb amputation is also not uncommon and it is these victims that have the highest mortality rate and often never make it to the hospital alive.[26] Thus, critical injuries account for 25 percent of terrorist victims overall compared with three percent in non-terrorism related injuries.[27]

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[23] Interviews conducted with Israeli police and medical personnel, Jerusalem, Israel, December 2002 and September 2003.

[24] Crabtree, "Terrorist Homicide Bombings: A Primer for Preparation," pp. 579-580.

[25] Sheffy, et al., "Terror-Related Injuries: A Comparison of Gunshot Wounds Versus Secondary-Fragments—Induced Injuries from Explosives," p. p. 301.

[26] Crabtree, "Terrorist Homicide Bombings: A Primer for Preparation," pp. 582.

[27] Sosna, et al., "Facing the New Threats of Terrorism: Radiologists' Perspectives Based on Experience in Israel," p. 237.

EMERGENCY RESPONSE IN ISRAEL, AUSTRALIA, AND THE UNITED KINGDOM

In Israel, the first call for help following a bombing will most likely be made to 101, the emergency telephone number of the Magen David Adom (MDA), Israel's version of the Red Cross, which is responsible for the country's medical-response teams and ambulances. MDA dispatchers follow a strict procedure. First they alert the ambulance teams, who are summoned by pager. Then, by both radio and pager, they notify

- the MDA's national headquarters, in Tel Aviv;
- the police (Israel has a national police force, not individual local forces); and,
- MDA regions and hospitals neighboring the site of the attack

The police or the MDA crews arrive first, depending on who is closer to the scene when the call comes in. The top priority is to tend to the victims and, simultaneously, to secure the area—to make sure that no other attacker strikes just as medical teams and more police officers arrive, among them counterterrorist, forensics, bomb-disposal, and intelligence squads. For the MDA the highest priority is to follow what Dr. Shapira, the deputy director general of Jerusalem's Hadassah Hospitals, calls the "golden half-hour rule": Get to victims during the critical minutes after an attack, when prompt medical attention—maintaining airways, controlling external hemorrhages, can mean the difference between life and death. This is termed "scoop and run."[28] That is, "only minimal treatment is provided at the attack site, like maintenance of an airway and pressure to stop external bleeding" before the victim is whisked into an ambulance and rushed to hospital. In Israel, ambulances carrying the injured will begin to arrive at hospitals within 20 minutes of the attack. Triage decisions will have already been made at the scene of the bombing: "The most severely injured survivors are triaged to a 'level 1 trauma center,' a hospital

[28] S.C. Shapria, et al., "Mortality in Terrorist Attacks: A Unique Modal of Temporary Death Distribution," *World Journal of Surgery*, vol. 30 (2006), p. 2 accessed at http://www.terrormedicine.org/publications_files/Mortality%20related%20to%20terror.pdf.

with advanced equipment and special expertise in trauma therapy. The less seriously injured may be sent to level 2 or 3 trauma centers, with efforts not to overload any single hospital."[29]

The Israeli emergency response thus comprises two protocols: "the organization of the pre-hospital phase and the cooperation and communication between the different rescue teams and medical systems in the region," as recounted immediately above; and, another regarding the hospital itself and the "general algorithm of hospital management throughout the MCE."[30] Hospitals in Israel are required by the government to be able to surge on very short notice and handle at least 20 percent more emergencies beyond its normal capacity. The newly-constructed Center for Emergency Medicine at Jerusalem's Hadassah Ein Kerem Hospital, for instance, can quickly double its emergency bed capacity to accommodate more than a 100 patients. Equally important, the center's four-feet-thick walls can withstand a major explosion and two sets of shatterproof glass can confine and re-circulate indoor air for more than a week. Not surprisingly given Israel's perpetual state of war with terrorists, tremendous priority is attached to ensuring the safety of emergency hospital personnel, the hospitals themselves and the victims brought to these care facilities.[31] Other hospitals, such as Tel Hashomer in Tel Aviv and the Western Galilee Hospital in Nahariya, actually have secure underground emergency treatment facilities "with hundreds of empty beds and IV stands at the ready."[32]

A second triage occurs at each hospital where patients may arrive as often as one every 20 seconds[33] (A U.S. Centers for Disease Control and Prevention analysis warned that in the event of some urban disasters, half of all casualties will arrive at a hospital over the period of an hour).[34] An 11-step procedure is followed, whereby the medical personnel in charge:

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[29] Shapira and Cole, "Terror Medicine: Birth of a Discipline."

[30] Shapira and Shemer, "Medical Management of Terrorist Attacks," p. 489.

[31] Ibid.," p. 490.

[32] Shapira and Cole, "Terror Medicine: Birth of a Discipline."

[33] Ibid.

- Confirm information
- Gather data; Type of event, location, estimated number of casualties, severity of injuries, estimated time of patients' arrival
- Evacuate emergency department
- Call for extra medical and paramedical staff
- Notify operating rooms, imaging, blood-bank
- Stop elective operations
- Assign a triage officer
- Decide whether decontamination will be needed
- Decide whether to set up extra admission areas
- Open control station
- Open public information center[35]

Suicide bombings are among the most lethal of all terrorist attacks. Almost 83 percent of those killed in a suicide bombing die at the scene. Of the survivors on average only about 17 percent subsequently die in hospital.[36] But, at the same time, many of the casualties may only be lightly wounded and indeed more than half of them are often discharged from the hospital within twenty-four hours of admittance.[37]

Israel's experience with MCEs arising from suicide and other terrorist bombings contrasts sharply in many important ways with New York City's experiences on 9/11. Fewer than a 1,000 injured survivors from the World Trade Center towers, for example, were admitted to two lower Manhattan hospitals in the hours after the attack. Of these, only 13 percent required surgery and hospitalization while 85 percent were both ambulatory and had mostly minor injuries. By comparison, about a third of Israeli victims of terrorism had severe trauma, 26 percent of

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[34] Rosenfeld, et al., "Is the Australian hospital system adequately prepared for terrorism?"

[35] Shapira and Mor-Yosef, "Medical Management of Conventional and WMD Terror," p. 383.

[36] Shapria, et al., "Mortality in Terrorist Attacks: A Unique Modal of Temporary Death Distribution," p. 1.

victims required admission to intensive care units, and one-half needed surgery. Duration of hospitalization of Israeli terrorist victims typically lasted longer than two weeks for about 20 percent of the injured. [38]

Australia's principal experiences with terrorist MCEs has primarily been as a result of the October 2002 suicide bombings in Bali, where 91 Australian citizens were killed and 66 injured (total deaths were 202 persons with 209 others wounded). The survivors were airlifted to Darwin, where the vast majority (61 persons) were treated at the Royal Darwin Hospital. Forty-five percent of these survivors were suffering from major trauma and all had severe burns. The large number of burn victims presented a special challenge to the Royal Darwin Hospital, as no one hospital in the country had the capacity or capabilities to manage that many blast and burn victims. Accordingly, Australian medical authorities decided to move them to other hospitals across Australia. The length of stay in hospital varied from 13 to 91 days. As an American public health analyst studying the Australian response to the suicide attack has noted, "The Bali experience serves as a warning of what could easily happen in a terrorist bombing [in the U.S.]. An incident producing '61 patients with severe burn and blast injuries' would overwhelm the resources of most areas of the country and would require secondary triage and redistribution of patients to other burn centers."[39]

Australia accordingly has drawn six key lessons from this experience and from studying that of other countries' emergency response to terrorist MCEs:

- Australian hospitals need to be prepared to deal with mass casualties from terrorist strikes, including bomb blasts and chemical, biological and radiation injury.

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[37] Interview with Dr. Shapira, Jerusalem Ein Kerem Hospital, 13 September 2003.

[38] Sosna, et al., "Facing the New Threats of Terrorism: Radiologists' Perspectives Based on Experience in Israel," p. 237.

[39] Crabtree, "Terrorist Homicide Bombings: A Primer for Preparation," pp. 583.

- Injuries from bomb explosions are more severe than those commonly seen in Australian hospitals.
- In disasters involving mass casualties in urban areas, many of the injured make their own way to hospital, often arriving before the more seriously injured casualties. Major hospitals in Australia should plan for large numbers of undifferentiated and potentially contaminated casualties arriving with minimal warning.
- It is critical that experienced and trained senior medical officers perform the triage of casualties in emergency departments, with frequent reassessment to detect missed injuries (especially pulmonary blast injury).
- Hospitals require well developed standard operating procedures for mass casualty events, reinforced by regular drills.
- Preparing for a major event includes training staff in major incident management, setting up an operational/control unit, nominating key personnel, ensuring there is an efficient intra-hospital communication system, and enhancing links with other emergency services and hospitals.[40]

London's emergency preparedness and response in the event of terrorist MCEs had been based on New York City's experience with the 9/11 attacks. However, the suicide terrorist bombings of three subway cars and bus on 7 July 2005 was a significantly different medical challenge. In New York City on 9/11, many persons died and only a few survived. The opposite occurred on 7/7 when only a small proportion of the victims lost their lives (52), but over 500 persons were injured.[41] London's long experience with Irish terrorism coupled with extensive planning, drills and other exercises ensured that the city's emergency services responded quickly and effectively in a highly coordinated

[40] Rosenfeld, et al., "Is the Australian hospital system adequately prepared for terrorism?"

[41] Andrew Berkman, "Lessons from London," Emergency (Queensland Australia), 6 July 2006, p. 11 accessed at: http://www.emergency.qld.gov.au/publications/emergency/2006_jul/pdf/Emergency_July_06_p10-13.pdf.

manner.[42] For example, according to the official lessons learned report,

> All five London Strategic Health Authorities played a part in the response and all London hospitals were placed on major incident alert, with 1,200 beds rapidly made available for more than 700 casualties arriving at accident and emergency departments over a period of several hours. The vast majority (more than 80%) were fit for discharge on the same day. Of the 103 casualties admitted to hospital, including 21 critically injured, three were to die of their injuries.[43]

The initial deployment of ambulances and emergency service personnel to the four blast sites entailed 73 ambulances and 12 response units, with many additional vehicles drawn from other sources.[44]

But even London's well-honed response to the MCE on 7/7 was not without problems:

- First, communications between first responders with hospitals or their control rooms were not as good as it should have been which resulted in the uneven and inappropriate distribution of casualties among area hospitals. In one instance, 300 casualties were transferred by double-decker bus from Tavistock Square (the scene of the bus bombing) to Royal London Hospital.
- Second, some hospitals weren't officially notified of the MCE and warned to expect casualties.
- Third, it proved extremely challenging to provide timely and accurate information, especially on casualty numbers, to government and the media.
- Lastly, multiple MCE sites within relatively close geographical proximity to one another created problems with some ambulance

[42] Australian Government, Attorney-General's Department Emergency Management Australia, *Lessons from London and Considerations for Australia: London Terrorist Attacks, 7 July 2005*, 2007, p. 6 accessed at http://www.ema.gov.au/agd/ema/rwpattach.nsf/VAP/(A80860EC13A61F5BA8C1121176F6CC3C)~LessonsfromLondon_220507.pdf/$file/LessonsfromLondon_220507.pdf

[43] Home Office, *Addressing Lessons From The Emergency Response To The 7 July 2005 London Bombings*, 22 September 2006, p. 22 accessed at: http://security.homeoffice.gov.uk/news-publications/publication-search/general/lessons-learned?view=Binary.

crews diverting themselves to the more visible sites than the less visible, but more critical ones, they had been sent to.[45]

CONCLUSION

What emerges from this discussion of the medical community's emergency response and preparedness for terrorist MCEs involving conventional explosions are two main points. First, that there are lessons we can learn from other countries' experiences with terrorist bombings and suicide terrorist attacks that would significantly improve and speed our recovery should terrorists similarly strike here. The experiences of foreign medical and emergency response communities and hospitals particularly in Israel, Australia, and Britain is highly relevant to their American counterparts.

Second, is that the best way to save as many lives as possible after a terrorist bombing or suicide attack is for physicians and other health care workers to undergo intensive training and preparation before an attack, including staging drills at hospitals, to cope with sudden overflow of victims with a variety of injuries from terrorist attacks. First responders must also understand that the specific demands of responding to bombings and suicide attacks are uniquely challenging. Death and injury come not only from shrapnel and projectiles but also from collapsed and pulverized vital organs, horrific burns, seared lungs and internal bleeding. It is crucial that emergency responders evaluate their response protocols and be prepared for the unusual circumstances created by a suicide attack. Moreover, given the increased financial stress on our nation's health system in general and urban hospitals in particular, any degradation of our existing capabilities will pose major challenges to our nation's readiness for an attack. Indeed, the opposite is required: a strengthening of our the capabilities at hospitals and for the emergency services that we require to effectively respond to a terrorism MCE involving conventional bombings or suicide attacks.

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[44] Attorney-General's Department Emergency Management Australia, *Lessons from London and Considerations for Australian*, p. 6

[45] Ibid., p. 17; and, Berkman, "Lessons from London," p. 17.

Let me conclude with a prophetic paragraph from the Gilmore Commission's (more formally known as the *Advisory Panel To Assess Domestic Response Capabilities For Terrorism Involving Weapons of Mass Destruction*) first annual report on national preparedness to address the threat of terrorist use of WMD in the U.S. that, as the commission's then executive director, I drafted nearly ten years ago.

> The Panel concludes that the Nation must be prepared for the entire spectrum of potential terrorist threats—both the unprecedented higher-consequence attack, as well as the historically more frequent, lesser-consequence terrorist attack, which the Panel believes is more likely in the near term. Conventional explosives, traditionally a favorite tool of the terrorist, will likely remain the terrorist weapon of choice in the near term as well. Whether smaller-scale CBRN or conventional, any such lower-consequence event—at least in terms of casualties or destruction—could, nevertheless, accomplish one or more terrorist objectives: exhausting response capabilities, instilling fear, undermining government credibility, or provoking an overreaction by the government. With that in mind, the Panel's report urges a more balanced approach, so that not only higher-consequence scenarios will be considered, but that increasing attention must now also be paid to the historically more frequent, more probable, lesser-consequence attack, especially in terms of policy implications for budget priorities or the allocation of other resources, to optimize local response capabilities. A singular focus on preparing for an event potentially affecting thousands or tens of thousands may result in a smaller, but nevertheless lethal attack involving dozens failing to receive an appropriate response in the first critical minutes and hours.[46]

[46] *First Annual Report to The President and The Congress of the Advisory Panel To Assess Domestic Response Capabilities For Terrorism Involving Weapons of Mass Destruction: I. Assessing The Threat*, 15 December 1999 (Washington, D.C., RAND Corp., 2001) p. 20 accessed at: http://rand.org/nsrd/terrpanel/terror.pdf

Chairman WAXMAN. Thank you very much, Dr. Hoffman.
Dr. Meredith.

STATEMENT OF JAY WAYNE MEREDITH, M.D.

Dr. MEREDITH. Thank you, Chairman Waxman, Representative Shays, distinguished members of the community, and guests. Thank you for the opportunity to appear before you today to discuss the impact of the proposed Medicaid regulations we have on trauma centers and trauma center preparedness in our country.

My name is Wayne Meredith. I'm the chairman of the Surgery Department at Wake Forest University School of Medicine, and I volunteer as the medical director of Trauma Programs at the American College of Surgeons.

What is trauma? Trauma is a major public health problem of which I am sure you are aware, but want to emphasize for you it is the No. 1 killer of people under the age of 44. That means if your children or grandchildren are going to die the reason they are going to die is most likely going to be from an injury. And the appropriate best way to keep that injury from happening is to have them treated in a trauma center, to make a trauma center available to them. That's been shown to reduce their risk of dying from a serious 25 percent. That's better than many other treatments that we consider standard treatment for any other condition. It is not standard treatment across America today because trauma center care, the systems are disorganized, the availability of trauma centers for providing that system are disorganized.

Trauma care is emergent, but not all emergency care is trauma care. These are serious injuries. It requires a level of readiness of the hospital, it requires a level of expertise of the people to be there to make it so that they can be available when it occurs.

I've had the great privilege of treating well over 10,000 patients over the years who have survived and overcome significant injuries. Just a small sampling of those patients include such patients as Greg Thomas, who was a 40-year old social worker riding to work. He was struck by a car and severely injured, he was wish-boned, tearing your leg apart and splitting your body halfway up the middle. He—he had a crushed chest, his pelvis was broken in two, his left leg finally had to be amputated, but he was able to survive because he got to a trauma center immediately, he had the kind of care he required. He now comes back to volunteer at our hospital to help with the psychological help for other people that are being treated there.

Josh Brown was being a good Samaritan, stopped to help someone change a tire, was struck by a car while he was doing that. Arrived bleeding to death in shock, and he had available to him a team of people waiting 24/7 to be available to take care of him and is therefore able to be discharged.

And a story I particularly like, Jason Hong was a student at our college. He worked—he was working in his family's convenience store in town. The convenience store was robbed. He was shot in his thigh, striking a major artery and vein in his thigh and was bleeding to death from that. Took him to the trauma center immediately. We opened his leg, stanched the bleeding which was profuse. Repaired those injuries by taking vein from his other leg and

placing it there. He survived, and, kept his leg. Now he ultimately came back to decide he wanted to be a doctor. He is now graduating from medical school this May and he will be joining our residency and starting to be a surgery resident in July of this year.

Trauma centers have to be prepared to respond on a minute's notice for all kinds of trauma, including those of terrorist attacks. They are the baseline of readiness, in my opinion, for any sort of capability to be prepared for the everyday type of terrorism that we can expect.

Are they ready? Unfortunate—and could they meet the surge of 450 type victims that occurred at 9/11? I think the result—the answer to that is no. We're not ready to be able to surge at that level the way trauma centers are set up today.

Saving people—there are other studies the National Foundation for Trauma Care, which I was the founding member of the board, also did a study about a year and a half ago which showed that our overall preparedness with trauma centers is about C-minus, if you look at that, for being prepared in our trauma centers to surge to a terrorist event.

Saving people from the brink of death, however, or from everyday trauma, even a terrorist attack, is costly and it's resources intensive but absolutely necessary. Our trauma care delivery system has several requirements all of which must be met.

Coordinated trauma system care. I talked in the very beginning statement that got you off track, Mr. Shays, extemporaneously talked about our lack of a coordinated system across our country. It is a very patchwork quilt of system currently and it needs to be organized.

The work force issues. Trauma surgeons are in great debt. We have a tremendous lack of trauma surgeons. Over half of our surgery—of our trauma fellowships go unfilled, we have no nurses. We have—if you more than regionalize trauma care there are not as many neurosurgeons in America today as there are emergency rooms in America today. There is not one—if they stayed in the house all the time, lived there, were chained there, could not leave, there aren't as many neurosurgeons in America as there are emergency rooms. Workforce shortage is going to be something that you—that we'll be facing dramatically going forward.

Trauma centers have to have sufficient resources to care for all their victims and to do the cost shifting it takes to take care of the uncompensated care and prepare for them. We must be prepared for the trauma that we see every day. Jason Hong gets shot in the leg on an everyday basis. We need to be prepared for the catastrophic events, the bridge collapses that occurred in Minnesota. We need to prepare for national disasters whether they are Katrina level or just earthquakes or tornados. And we need to be prepared for the major events that could occur from terrorism, which I think are more likely to be bombing in a cafe than they are an anthrax attack or some major bio event, I think is much more likely. So trauma centers are threatened by that.

The effects of the Medicaid changes will be dramatic in our hospital. It is estimated it will cost us—let me see. Medicaid regulations is not something—it will be $36 million from our hospital. It currently costs about $4½ million of infrastructure to keep the

trauma center alive. And we use about $13 million in costs in uncompensated care. Add to that $36 million our trauma center will go under. We will not be a part of the infrastructure for health care in our part of the region. We serve western—all of western North Carolina.

So with that I'll truncate my remarks and thank you for this. I just beg you to stop the Medicaid cuts and enact H.R. 5613, the Dingell-Murphy bill, fully funded the trauma systems planning program and ensure maintenance of systems and adequately fund H.R. 5942, the Towns-Burgess-Waxman-Blackburn legislation, and fully fund the hospital preparedness program and hospital partnership grants to ensure the highest level of preparedness, funding for all hospitals and most particularly for trauma centers. I want to thank the committee for having these hearings and to thank you for having me participate in them.

[The prepared statement of Dr. Meredith follows:]

STATEMENT OF

J. WAYNE MEREDITH, M.D.
CHAIRMAN OF SURGERY
WAKE FOREST UNIVERSITY BAPTIST MEDICAL CENTER

BEFORE THE
HOUSE COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

HEARING ON

THE LACK OF HOSPITAL EMERGENCY SURGE CAPACITY:
WILL THE ADMINISTRATION'S MEDICAID REGULATIONS MAKE IT WORSE?

MAY 5, 2008

Introduction

Chairman Waxman, Ranking Member Davis, Representatives McHenry & Foxx from my home state, Distinguished Members of the Committee and guests, thank you for the opportunity to appear before you today to discuss the impact the proposed Medicaid regulations would have on trauma center preparedness.

My name is Dr. Wayne Meredith and I serve as Professor and Chairman of Surgery at Wake Forest University Baptist Medical Center. I am a trauma surgeon and have devoted my career to caring for victims of traumatic injury, teaching our next generation of trauma surgeons, and also to building the best possible system of trauma care delivery. I currently serve as Medical Director of Trauma Programs for American College of Surgeons, and was a founding Board member for the National Foundation for Trauma Care, an organization that seeks to secure the economic viability of America's trauma centers.

Wake Forest University Baptist Medical Center, one of the nation's preeminent academic medical centers, is an integrated health care system that operates 1,154 acute care, rehabilitation and long-term care beds, outpatient services, and community health and information centers. Baptist Medical Center has 20 subsidiary or affiliate hospitals and operates more than 100 outreach activities throughout the region, including satellite clinics, health fairs and consulting services. It provides a continuum of care that includes primary care centers, outpatient rehabilitation, dialysis centers, home health care and long-term nursing centers.

Although its primary service area is a 26-county region in northwestern North Carolina and southwestern Virginia, Wake Forest University Baptist Medical Center in the past year has served patients from 98 (of 100) North Carolina counties, all 50 states, the District of Columbia and Puerto Rico, and several foreign countries. Wake Forest University Baptist Medical Center's

component institutions carry out a joint mission of patient care, education, research and community service.

Wake Forest University Baptist Medical Center is one of six Level I Trauma Centers in the state of North Carolina, and is the first trauma center in the state that has been verified by the American College of Surgeons as a Level I Adult and Pediatric Trauma Center. This is the region's only Level 1 service. Between 2800-3000 trauma and burn patients (85% blunt/ 15% penetrating) are admitted to the trauma center each year from a large catchment area of Western North Carolina, Southern Virginia and Eastern Tennessee. This large population base allows for an unusual combination of a very busy trauma center in a city of a manageable size.

What is Trauma?

Trauma is a major public health problem. It is the leading cause of death for children, youths, and adults under the age of 34. It kills more Americans than strokes and AIDS combined and yet less than 10% of hospitals have a trauma center and only 8 states have fully developed trauma systems.

All trauma care is emergent but not all emergency care is trauma. Emergency rooms and departments treat ill and injured people, while trauma centers handle the most severe, life-threatening blunt force and penetrating injuries. Emergency medical technicians (EMTs) transport complex injury victims meeting predefined triage criteria past local hospitals to trauma centers where a sophisticated and highly trained interdisciplinary team of health care professionals are immediately available to provide the services needed to save that person's life and prevent further disability or physical deterioration. Trauma centers dedicate extensive staff, physician and faculty resources around the clock, so that seriously injured patients have the best possible chance of survival. Seriously injured victims treated in trauma centers have a 25% lower risk of death. The availability of trauma centers to care for these patients is the most effective treatment strategy for the number one killer of citizens under the age of 44 and a major cause of death and disability for all ages.

A Level I Trauma Center has a full range of specialists and equipment available 24-hours a day and admits a minimum required annual volume of severely injured patients. Additionally, a Level I Trauma Center has a program of research, is a leader in trauma education and injury prevention, and is a referral resource for communities in neighboring regions through community outreach. The Level I Trauma Center must have a program for substance abuse screening and provide brief intervention to patients as appropriate.

A Level II Trauma Center usually works in collaboration with a Level I Center but may be the only tertiary resource in a rural state such as Montana or Wyoming. It provides 24-hour availability of all essential specialties, personnel and equipment. There are no minimum volume requirements. These institutions are not required to have an ongoing program of research or a surgical residency program but must have an injury prevention program as well as conduct substance abuse screening.

A Level III Trauma Center does not have the full availability of specialist except surgery and orthopedics in most states, but does have the resources for the emergency resuscitation, stabilization, emergent surgery, and intensive care of most trauma patients. A Level III Trauma Center has transfer agreements with Level I and/or Level II Trauma Centers to assure back-up resources for the care of patients with severe injuries. The Level III Trauma Center has an injury prevention program.

In many, but not most states, trauma centers participate in coordinated systems of trauma care delivery to ensure that patients are transported to the right place at the right time. The development of trauma systems is more advanced in some states than others. I am proud that North Carolina has one of the most advanced trauma care systems in the nation. The ACS and other trauma organizations are dedicated to ensuring continued development of coordinated trauma care delivery systems in all states.

Golden Hour – Getting Right Patients to Right Place at Right Time Saves Lives

The golden hour is the first 60 minutes after the occurrence of a major multi-system trauma. It is widely believed that the victim's chances of survival are greatest if he or she receives specialized trauma care within the first hour. Trauma care delivery arose out of our experience in treating battlefield injuries in Vietnam and has grown and developed tremendously since that time.

I have had the great privilege of treating well over ten thousand patients over the years who survived and overcame life-threatening injuries. Just a small sampling of those patients include:

- Greg Thomas, aged 40 was riding his bicycle when he was hit by a car and severely injured. He arrived at our trauma center in shock and activated at a Level I. His injuries included a flailing chest, pelvic fractures and his left leg had to be amputated. Even though he is disabled, Greg still celebrates life and visits the trauma center every year to say thank you.

- Josh Brown was being a good Samaritan and stopped to help someone change their tire when he was stabbed in the neck. He arrived hypertensive and losing blood but because we had a 24/7 team waiting, he was immediately treated and able to be discharged within a short period of time.

- Jason Hong was a student at Wake Forest University. His parents lived in Winston-Salem and owned a convenience store. Jason was working at the store one night, when the store was robbed and he was shot in the thigh. The bullet hit one of his main arteries in his leg and Jason was losing enormous amounts of blood. Fortunately for Jason, he was brought immediately to the trauma center at Baptist. We were able to staunch his hemorrhage before he bled to death and repair his injured artery and vein using a section of vein harvested from his other leg. We also had to incise the injured leg to release the pressure that was building in it. If we were not able to treat him in time, Jason would have lost his leg or even worse, died. But not only did Jason survive, he was inspired to become a doctor. Jason has been a student at Wake Forest University School of

Medicine at the Bowman Gray Campus and has now graduated from medical school and will become a surgery resident beginning July 1.

Trauma Center Preparedness Needs Improvement

Trauma centers must be prepared to respond on a minutes notice for every day traumatic injuries, as I have just described, and for catastrophic, natural disaster and terrorist attacks. When examining the level of preparedness for terrorist attack among our nation's trauma centers, it is essential to highlight that on 9/11, St. Vincent's Medical Center in Manhattan, (which is a Level I trauma center) had a surge of 848 patients from the World Trade Center attack, of whom 450 were seen in the first two hours. Are all of our nation's trauma centers prepared for that kind of surge? Unfortunately, the answer is a resounding no.

In the 2006 *U.S. Trauma Center Preparedness for Terrorist Attack in the Community Report*, the National Foundation for Trauma Care, in conjunction with the Centers for Disease Control, found that many of our nation's trauma centers are not fully prepared for a terrorist attack. The *Trauma Center Preparedness Report* identified only seven highly prepared trauma centers and numerous trauma centers with below average preparedness scores five years after 9/11. To put this in more stark terms, of the 175 surveyed trauma centers, the average overall preparedness score was 74 out of 100 -- that would constitute C- if we were grading our average level of preparedness.

The *Trauma Center Preparedness Report* identified key factors of high level preparedness, including most significantly, higher funding amounts from multiple sources. Lower funding amounts for trauma centers generally resulted in lower preparedness scores. The Report provided numerous recommendations for improvement in preparedness for our nation's trauma centers including ensuring adequate funding for trauma centers based on their proximity to hazards and threats. Implementation of all the critical recommendations made in the Report requires a significant expenditure of human and fiscal resources.

Scarcity of Resources for Trauma Care

Saving people from the brink of death, whether from every day trauma or due to a terrorist attack, is a costly and resource intensive but absolutely necessary endeavor. For us to fulfill that obligation for all trauma victims, our trauma care delivery system has several basic requirements, all of which must be met:

Coordinated Trauma Systems. We must have coordinated, integrated, fully developed and fully funded trauma systems at the state and local level to ensure critically injured patients are taken to the right place at the right time. Unfortunately, federal funding for trauma systems has been extremely limited over the past decade and was eliminated entirely last year.

Trauma Surgeons, Nurses and other Caregivers. We must have enough trauma and other subspecialty surgeons, nurses and other caregivers who are available 24/7 for all who need their specialized care. Unfortunately, high malpractice insurance and other challenges are

leading to a severe shortage of current and future trauma surgeons and other subspecialties providing trauma care including neurosurgery - and orthopedic surgery subspecialties. Only about half of the nation's trauma surgery residencies are filled.

Trauma Centers. Trauma centers, and the hospitals in which they are housed, must have sufficient resources to provide trauma services to all victims of traumatic injury, regardless of their ability to pay. Unfortunately, federal funding for hospital preparedness keeps declining and there is currently no federal funding to directly support trauma centers for their core mission and uncompensated care costs, and no means by which the federal government can help to prevent a trauma center closure or downgrade.

Preparation for all Kinds of Trauma. We must be prepared for all kinds of trauma:

- For trauma we see everyday – victims of car crashes, gun shots, construction accidents and the like.
- For catastrophic events – the bridge collapse in Minneapolis, or the pedestrian bridge at the Speedway outside of Charlotte, or the bus full of children flying off the bridge in Atlanta, or the carnage at Virginia Tech.
- For natural disasters from which traumatic injury results – for hurricanes, earthquakes and tornados.
- And, as we learned so well on September 11, we must be prepared for terrorism by whatever means, including by blast attack.

The delivery of trauma care requires money to pay for all of what I've just described. It requires fair and reasonable Medicaid reimbursement to ensure that safety-net hospitals have sufficient resources with which to maintain their trauma centers. It requires full funding of the federal trauma systems planning program. It also requires full funding for the Hospital Terrorism Preparedness Program and Hospital Partnership Grants. And, it requires directed funding to trauma centers to help defray the costs of core mission activities and uncompensated care, provide emergency funding to prevent closures or downgrades, and enable the infusion of federal funding in the event of a natural disaster or terrorist attack.

Threat to Trauma Care Delivery by Medicaid Regulations

Trauma centers are funded and supported by their hospitals, most often safety net public or non-profit hospitals whose mission it is to care for all, regardless of their ability to pay. Across the nation, the costs of practicing medicine and delivering trauma care have steadily increased. Meanwhile, the reimbursements to trauma centers and physicians from health plans, managed care, Medicare, Medicaid, and safety net programs for the uninsured have steadily decreased and are now gravely threatened by the Medicaid regulations. And somehow, in all of this chaos, our obligation to be prepared for a terrorist blast attack has grown exponentially.

The annual cost of running our trauma center at Baptist Medical Center is approximately $4.5 million. This is the cost for us to be prepared for the approximately 1600 trauma patients we care for each year and does not include our uncompensated care costs. The expected loss to Baptist if the Medicaid regulations are not stopped by the Congress is $36 million per year. The

only funding our region—which is comprised of Baptist Medical Center, one Level II trauma center, one Level III trauma center, 26 hospitals, and 17 EMS agencies—receives for all-hazards preparedness is approximately $2 million from the State of North Carolina which is largely derived from the federal Hospital Preparedness Grant Program. The numbers speak for themselves.

Baptist Medical Center is not alone in facing the challenges of funding our trauma center. If the Medicaid regulations go into effect, North Carolina hospitals would lose a collective $387 million per year. The hardest hit among them by the Medicaid regulations are those eight safety-net hospitals which serve as Level I and II trauma centers and operate the air ambulance services in their region.

According to the National Foundation for Trauma Care, since 2000, at least 19 hospitals across the nation have closed their trauma service and a number have downgraded levels. How many more closures and downgrades might we have if the Medicaid regulations are allowed to go into effect? I don't really know and I don't want to find out the hard way. The patients I described earlier depended on me and Baptist Medical Center to save their lives. We are all depending on you to ensure our nation's trauma centers have the ability to treat all trauma victims in the future.

The Congress should complete final enactment of H.R. 5613, the Dingell-Murphy legislation, to stop the Medicaid cuts and protect the ability of safety-net hospitals with trauma centers to maintain this critical public health function. The Congress should also enact and fully fund the National Trauma Center Stabilization Act, H.R. 5942, recently introduced by Representatives Edolphus Towns, Michael Burgess, Chairman Waxman, and Marsha Blackburn. I am grateful for their leadership and championship of this vital legislation.

Conclusion and Recommendations

Mr. Chairman and Committee Members, I commend you for holding this hearing today. To summarize what needs to be done to ensure our nation's trauma care delivery system is ready and able to care for all victims of traumatic injury and be prepared for terrorism and everyday trauma, I respectfully provide the following recommendations for your consideration:

1. Stop the Medicaid cuts and enact H.R. 5613, the Dingell-Murphy bill, which passed the House with overwhelming support.
2. Fully fund the Trauma Systems Planning Program to ensure maintenance and further development of coordinated trauma care delivery systems in all states.
3. Enact and fully fund H.R. 5942, the Towns-Burgess-Waxman-Blackburn, legislation to provide federal funding for the core mission, uncompensated care and emergency needs of trauma centers.
4. Fully fund the Hospital Preparedness Program and the Hospital Partnerships Grants to ensure the highest possible level of preparedness funding for all hospitals, and most particularly for trauma centers.

Thank you for the opportunity to testify before you today.

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Chairman WAXMAN. Thank you very much, Dr. Meredith. Dr. Welch.

STATEMENT OF COLLEEN CONWAY-WELCH, PH.D.

Dr. CONWAY-WELCH. Good morning. My name is Colleen Conway-Welch. I've been dean at the School of Nursing at Vanderbilt for 24 years.

Chairman WAXMAN. Would you pull the mic just a little closer? You don't have to move closer, pull the mike closer.

Dr. CONWAY-WELCH. Thank you.

Over the last decade, however, I have taken a special interest in the area of emergency preparedness. I am here today to make the link between the consequences of reduced Medicaid funding, a fragmented public health infrastructure, and a reduced level of emergency preparedness, and to urge the committee to recommend a moratorium on these actions until at least March 2009.

I want to make three specific points about implementation of the following three changes, limiting Medicaid payments to public providers only, dropping Medicaid funding for graduate medical education and limiting Medicaid dollars for services in out patient settings.

If the changes anticipated for May 26th occur, it will be virtually impossible to fix these rules legislatively in a rushed and piecemeal manner. And DHHS will be hard pressed to effectively respond HSPD 21, which directs the Department to look at regulations that impact emergency preparedness.

If Medicaid dollars are reduced in these three areas, a reduction in personnel and readiness will occur in our hospitals and emergency departments across the country and, even worse, it will occur in the midst of a serious and intractable nursing and nursing faculty shortage and limit our ability to respond to a disaster, particularly a blast or explosive injury with serious burns.

It is also reasonable to assume that States, including Tennessee, will not hold the providers harmless if Federal matching funds are lost. There would be no easy way to redirect or make up money to those who are losing it, such as the medical schools and safety net provider hospitals. Even if the State were able to redirect State dollars to areas eligible for a Federal match, those funds would most likely be distributed in Tennessee to the managed care organizations and then be part of the overall payment structure of all of our hospitals.

I want to speak now specifically to the three changes. No. 1, limiting payment only to providers who are a unit of government puts our rural, community, private, and 501(c)(3) hospitals at even greater risk since they must already pick up the slack of escalating numbers of uncompensated care and are tied to a public health infrastructure that is increasingly unfunded, unavailable and marginally functional. In Tennessee this would result in only one hospital, Nashville Metro General Hospital, being included. The TennCare Medicaid program would lose over $200 million per year in matching funds. This would put all of the hospitals in Tennessee, except Metro General, in a position of cost shifting and service reductions, as well as limiting access even further.

For example, Vanderbilt already provides more than $240 million a year in uncompensated care. While I'm discussing Tennessee, these are issues across the country.

All disasters are local, that is true, and conventional explosive attacks are especially local. The casualties are immediate and nobody should expect outside help for at least 24 hours. Only a true system of local, functional, systematically linked emergency departments and hospitals can address the casualties of this most probable form of attack.

Proposal two, eliminating Federal support for graduate medical education programs will result in a reduction of medical residents in a wide variety of settings, including ERs, trauma burn and intensive care units. They will also not have the support of my skilled trauma nurses since these numbers will be reduced as well.

As an example, in Tennessee the four medical schools in the State would lose $32 million annually. These schools also serve as the safety net providers and would be forced to reduce their numbers of students.

Proposal three, limiting the amount and scope of Medicaid payment for outpatient services will weaken our ER ability to handle a surge of victims. Our large hospitals will quickly experience automobile gridlock.

It is also absurd to think about evacuating hospitals in a time of disaster with the high acuity level we maintain every single day, including patients on ventilators. At Vanderbilt, for example, the burn unit and the ICUs are already at capacity. If disaster hits, health care providers will need to be dispatched to community and rural clinics to help them care for patients with serious injuries who cannot be transported or accommodated by hospitals. As clinics, we do services and personnel commensurate with reduced Medicaid dollars. Their ability to avoid triage and care to patients will be significantly impacted.

Federal disaster preparedness money that comes to Tennessee is much appreciated. However, Federal money does not require an outcome of increased documented operational capacity building and it should. Tabletop exercises are marginally useful, are an income opportunity for Beltway bandits. However, lessons learned from one exercise are not necessarily applied to the next.

To many health care professionals of both political parties in the field of emergency preparedness, it appears that DHHS and DHS do not have a mechanism to assess and monitor the extent to which States, counties and cities have the capability and game plan in place to respond to a disaster such as a blast explosion and are not able to provide guidance on which to base these plans.

There is no one place anywhere in our Nation or at any level of government where one can go to receive reliable information on resources; for example, how many burn beds there are in Tennessee or how many ICU beds there are in Nevada. There is no one-stop shop to answer it on a Federal level and disasters are frequently not limited to one State. So regional statistics and information are needed. For example, Tennessee has 48 burn beds, 28 of which are at Vanderbilt and the eight Southeast States have a total of 240, but I had to go to the American Burn Association to get those numbers.

In summary, I am encouraging a moratorium on these Medicaid changes, a requirement that coordination between and among various Federal, State and local entities be enhanced to achieve a double whammy; namely, improving emergency preparedness response while improving the fractured public health infrastructure. It is important to point out that continued cuts to providers negatively impact every service a hospital provides. Vanderbilt has historically soaked up these reductions and looked for other sources of revenue, but that is becoming more and more difficult.

It is logical to assume that we would have to cut such programs as helicopter transport, HIV/AIDS programs and certain medical and surgical specialties, including emergency preparedness. We now support emergency preparedness in a robust way, but we would need to limit our participation and regional drills and internal administrative planning, as well as reduce our commitment or eliminate stockpiling of medical supplies and equipment that are critical.

In conclusion, please extend the moratorium until next year. Charge DHHS and DHS to thoughtfully work together to address the declining public health infrastructure from the prospective of improving our emergency preparedness, and urge that the rules be withdrawn since Congress did not direct their propagation. A simple and immediate cut in Medicaid funding to these three areas is not a thoughtful solution, will not work and will have a devastating effect on our hospitals and providers to respond in a disaster. In the final analysis if these rules are enacted as proposed when our citizens need us most, we will not be there.

Thank you.

[The prepared statement of Ms. Conway-Welch follows:]

Good Morning. My name is Colleen Conway-Welch. I am the Dean of the School of Nursing at Vanderbilt University, and currently hold the Nancy and Hilliard Travis Chair of Nursing. I have worked every day as a nurse for over 43 years in both nursing service and nursing education. My goal during the last 4 decades has been to ensure sufficient quality health care for our population, no matter the situation. Over the last decade, I have taken a special interest in the area of emergency preparedness.

While disaster preparedness and community symptom surveillance have always been present in nursing curriculum either formally or informally, in 2000, at the urging of and with funding from the Office of Emergency Preparedness of HHS, I founded The International Nursing Coalition for Emergency Preparedness, now known as Nursing Emergency Preparedness Education Coalition. It is a network of organizations that uses technology to serve as a clearing house for emergency preparedness nursing education, competencies, and curriculum. In 2004-2005, I received funding from DHHS to start a Middle Tennessee Medical Reserve Corps, which is housed at the Vanderbilt School of Nursing, along with our National Center for Emergency Preparedness. I was named to Secretary Thompson's Secretary's Advisory Committee on Public Health Preparedness in 2002 – 2006 and presently serve on the Institute of Medicine's Committee that is preparing a Workshop this summer on Medical Preparedness for a Nuclear Explosion.

I am here today to describe the likely consequences to hospital emergency preparedness if three of the proposed seven cuts in Medicaid occur on May 26, to make the link between the consequences of reduced Medicaid funding and the level of emergency preparedness and to urge the committee to recommend a moratorium on these actions until at least March 2009.

Specifically, implementation of the following three changes:

1. Limiting Medicaid payment to public providers only
2. Dropping Medicaid funding for Graduate Medical Education (or GME)
3. Limiting Medicaid dollars for services in outpatient settings

Will have a devastating effect on emergency preparedness and our ability to respond to the terrible toll that disasters take on our nation's citizens. It will severely curtail the response of personnel and medical facilities that depend on Medicaid dollars.

If the changes anticipated for May 26 occur, it will be virtually impossible to "fix" these rules legislatively in a rushed and piece-meal manner and HHS will be hard pressed to effectively respond to HSPD21 which directs the department to look at regulations that impact emergency preparedness, especially emergency departments and Level I Trauma Centers. If Medicaid dollars are reduced in these three areas, a reduction in personnel and readiness will occur in our hospitals and emergency departments across this country; even worse, it will occur in the midst of a serious and intractable nursing shortage that will have a significant negative impact on readiness of our hospitals and emergency rooms to respond to a disaster, particularly a blast/explosive injury with significant burn injuries, which frankly, can and do occur in our communities on a regular basis, let alone as a terrorist event. The red

impact of these regulations is to remove billions of dollars from an already stressed system. It is also reasonable to assume that states, including Tennessee, will not hold the providers harmless if federal matching funds are lost. There would be no easy way to redirect money to those who are losing it, such as the Medical Schools and the Safety Net Providers. Even if the State was able to redirect state dollars to areas eligible for Federal match those fully matched funds would most likely be distributed to the Managed Care Organizations in Tennessee on a per member per month (PMPM) basis and then be part of the payment structure for all hospitals. There is simply no easy way to redirect money to the providers. For example, across Tennessee, we have only forty-eight burn unit beds and in the eight state southern regions we have just 240. This is to serve a population of fifty-eight million. Of even greater concern, if something happened tomorrow, we really only have a limited percentage of hospital beds available for use, because the rest are filled with complex patients that simply cannot be moved without quality of their care in jeopardy.

To better present the impact of these proposed changes, I want to speak specifically to the three proposed changes in the Medicaid program:

Proposal 1:

Limiting payment only to providers who are a unit of government puts our rural, community, private and 501(c)3 hospitals at an even greater risk, since they already must pick up the slack of escalating numbers of uncompensated care and are tied to a public health infrastructure that is increasingly unfunded, unavailable, and marginally functional. In Tennessee, this would result in only one hospital, Nashville Metro General, being included. The TennCare program would lose over $200 million per year in matching funds.

TennCare would likely need to reduce rates, limit benefits and change eligibility criteria to reduce the number of TennCare eligibles. This will put all the hospitals in Tennessee in the position of cost shifting and services reductions as well as limiting access even further. The safety net hospitals, which play an even bigger role in emergency preparedness, would need to make difficult decisions to cut services and limit access. While I am discussing Tennessee, these are issues that would occur in every hospital in the country, many of which are more financially vulnerable. All disasters are local, and conventional explosive attacks are especially local. The casualties are immediate, and nobody should expect help for at least twenty-four hours. Medical experts tell us that the most critical time is already over by then. Only a system of local functional emergency departments can address the casualties of the most probable form of attack. On the battlefield, it used to be the "golden hour", then "the golden fifteen minutes"; it is now the "golden five minutes".

Proposal 2:

Eliminating federal support for Graduate Medical Education or GME programs in and across the country will result in a reduction in medical residents in a wide variety of settings, including emergency departments; Trauma, Burn, and Intensive care Units. They will also not have the support of many skilled trauma nurses since these numbers will be reduced as well. As an example, what this would mean in Tennessee, the four medical schools in the state will lose $32M annually. These schools also serve as the safety net providers and will be forced to reduce their numbers of students. Even more

important, this is done in the face of an impending MD shortage and will result in even fewer MDs to respond to disasters.

Proposal 3:

Limiting the amount and scope of Medicaid payment for outpatient services will result in our hospitals experiencing even greater incapacity and gridlock. It is absurd to think about evacuating hospitals in a time of disaster with the high acuity level we maintain on a day-to-day basis. At Vanderbilt Medical Center, for example, the Burn Unit and ICUs are already at capacity. This typical of almost every major community in the country. Health Care Providers will need to be dispatched to surrounding clinics to help them care for patients with serious injuries who cannot be transported or accommodated by hospitals. As clinics reduce services and personnel, commensurate with reduced Medicaid dollars, their ability to provide vital triage and care to patients injured in a disaster will be reduced and they will have fewer resources available. Of even greater concern, this will not be limited to only disaster and surge, but will affect every aspect of care.

To many health care professionals of both political parties in the field of emergency preparedness, it appears that HHS and DHS do not have a mechanism for accountability to assess and monitor the extent to which states and major cities have the capability and game plan in place to respond to a disaster such as a blast explosion. In fact, DHS and HHS have not been able to provide guidance on which to base these state plans. The current array of fifteen scenarios, while mesmerizing reading, fails to provide even rudimentary guidance and readiness. While I understand that this is not seen as a federal responsibility, we have learned from Katrina that citizens turn to the federal government in expectation of a

responsive coordinating role. I understand that there are territorial and political issues, but there is no one place anywhere in our nation, or at any level of government, where one can go and receive reliable information on how many burn beds there are in Tennessee – or how many ICU beds in Nevada, etc. States may well have that information in a variety of offices, but there is no "one-stop shop" that can answer this on a federal level and disasters are frequently not limited to one state, so regional statistics and information are needed. For example, Tennessee has forty-eight burn unit beds, twenty of which are at Vanderbilt and the eight states in the southeast region have a total of 240. I had to go to the American Burn Association to get these statistics.

I am encouraging a moratorium on these changes as an opportunity to enhance coordination between and among the various federal, state, and local entities and achieve a "double whammy", namely improving emergency preparedness response while improving the public health infrastructure, which will be desperately needed in an emergency. For example, the public health infrastructure was virtually paralyzed after Katrina in New Orleans after years of underfunding and neglect.

It is important to be clear that continued cuts to providers ultimately negatively impacts every service hospitals provide, including emergency preparedness as well the level and quality of care to patients. Vanderbilt Medical Center has historically absorbed these reductions and looked for alternative revenue sources. This has been relatively successful so far but in the world of increasing regulation, it becomes more and more difficult. Vanderbilt will be forced like everyone else to downsize or eliminate programs that generate no margin. It is too difficult to speculate what those might be but logical candidates would be helicopter transport, HIV/AIDs program, and certain medical and surgical specialties.

As Vanderbilt Medical Center is forced to make these difficult choices, it will also need to look at its role in Emergency Preparedness. Vanderbilt supports this program in a very robust way now but we would need to limit our participation in regional drills and internal administrative planning in preparation for a regional or national emergency as well as to reduce or eliminate our commitment to stockpiling of medical supplies and equipment that are crucial in a national emergency.

In conclusion, please extend the moratorium into next year and charge HHS and DHS to thoughtfully work together to address the declining public health infrastructure from the perspective of improving our emergency preparedness or even better, urge that these rules be withdrawn since Congress did not direct their propagation. It is vital that the very critical issues identified in this testimony be addressed. The problems are real; a simple and immediate cut in Medicaid funding to these three areas is not a thoughtful solution, will not work and will have a devastating effect on the ability of our hospitals and providers to respond to a disaster. In the final analysis, if these rules are enacted as proposed, when our citizens need us most, we will not be able to be there.

Attachment 1

Hospitals Face Financial Squeeze
By JACQUELINE PALANK
May 1, 2008

More than half of U.S. hospitals aren't seeing enough patients to provide sufficient revenue to fund operations and are "teetering on the brink of insolvency" or already are insolvent, according to a study.
Restructuring firm Alvarez & Marsal said more than 2,000 of the nearly 3,900 acute-care hospitals the firm studied don't make a profit treating patients.
Nearly 750 hospitals that do turn a profit still don't have enough to reinvest in improvements or other essential expenditures, the firm's study found.
While many hospitals continue to operate despite insolvency, an increasing number are filing for bankruptcy as part of a trend experts said is sure to continue.
"We're seeing hospital insolvencies and hospital bankruptcies -- it's the heyday right now," said George D. Pillari, a managing director in Alvarez & Marsal's health-care group who worked on the study. "We're going to see continued insolvencies; we're going to see more bankruptcies this year than last year."
There is a "top tier" of about 500 to 1,000 hospitals that are consistently profitable, have excellent credit ratings and claim a substantial share of the market, Mr. Pillari said, and "then there's everybody else."
The problems facing the industry are widespread, but many hospitals have too many beds and too few patients, said Gerald H. Gline, a bankruptcy attorney at Cole, Schotz, Meisel, Forman & Leonard PA who has worked on hospital bankruptcy cases in New Jersey.
"Hospitals are also competing with same-day surgery centers and outpatient clinics and all sorts of ways to deliver health care," Mr. Gline said.
"There are just too many hospitals."
While occupancy levels decline, the cost of care continues to rise. The rates of reimbursement from Medicare and Medicaid are down, Mr. Gline said, and there is an increasing number of uninsured patients.
Alvarez & Marsal, which looked at 3,861 of the country's approximately 4,900 short-term, acute-care hospitals, found that 2,044 don't earn a profit on patient care. An additional 744 hospitals earn less than what they need to fund day-to-day operations as well as the most basic capital expenditures, like making facility repairs. The study, released last week, also found that hospitals' capital expenses are underfunded in the range of $10 billion to $20 billion because they are using these dollars to fund their operations.
"You don't even have enough money to then fix broken sinks or broken elevators," Mr. Pillari said.
Nor are hospitals immune to the credit crunch that has forced companies in a host of industries to take on costlier loans, if they can get financing at all. Mr. Pillari said lenders that last year were willing to finance a hospital at an amount that was five or six times its cash flow are now making loans only in amounts that are double or triple cash flow.
"What had always been a relatively comfortable financial environment in health care has become a lot more treacherous," he said.
Hospitals then turn to other, often unsteady, sources of revenue, such as the cash that a gift shop or parking lot brings in, as well as philanthropy or aid from local and state governments.
But these "Band-Aid fixes" haven't been enough to cover what is actually a gaping wound, Mr. Pillari said. "This whole industry is just kind of sliding slowly into insolvency," he said.
Before the industry can bottom out -- which Mr. Pillari said may not be for another few years -- more hospitals will have to seek drastic fixes such as mergers or bankruptcy filings to cure their balance sheets.
"Hospitals can make it. They can get by even if they're insolvent," he said.
"But there's not much of a future unless the capital structure is fixed."

Analysis of Proposed Medicaid Regulations

1. Cost limits for public providers

The regulation states that the entities involved in the financing of the non-Federal share of Medicaid payments must be a unit of government. The cost limit provision does not apply to Medicaid Managed Care Organizations (MCOs) and DSH payments are not subject to the cost limit provision.

The only hospital in Tennessee that would qualify as a unit of government under these regulations is Metro General. Because the Regional Medical Center is a 501(c)3 organization, they would not qualify even though they are a safety net hospital and provide a large amount of charity care.

Estimated reduction in federal Medicaid funds to Tennessee over each of the next 5 years: $200M per year

2. Payments for Graduate Medical Education

The regulation states that payments associated with GME are not expenditures for medical assistance that are federally reimbursable under the Medicaid program. In the past, CMS had allowed States to include the cost of hospital GME activities as a component of inpatient and outpatient Medicaid services. GME would no longer be considered a health service covered by the Medicaid program.

Many rural and low income areas of Tennessee would lose services currently provided by residents training in primary care settings other than hospitals.

Estimated reduction in federal Medicaid funds to Tennessee over each of the next 5 years: $32M per year

3. Payment for hospital outpatient services

The regulation would align the Medicaid definition of outpatient services with the Medicare definition. Currently, Medicaid has a broader definition which includes non-facility services (i.e. physician and professional services) and/or non-traditional outpatient hospital services (i.e. school-based and rehabilitative services).

Outpatient services are covered by Managed Care Organizations in the State of Tennessee. Because the payment rates for all the services they cover are negotiated by MCO's with providers, there is not a direct correlation to the traditional Medicaid covered services.

Estimated reduction in federal Medicaid funds to Tennessee over each of the next 5 years: Unknown

4. Provider taxes

The regulation would lower the maximum amount that a state could receive from a health care-related tax from the current rate of 6% to the proposed rate of 5.5%.

In Tennessee, there is a 6% gross receipts tax currently in effect for Intermediate Care Facilities for the Mentally Retarded. The proposed rule would lower the tax rate to 5.5%.

Estimated reduction in federal Medicaid funds to Tennessee over each of the next 5 years: $1.5M per year

5. Coverage of rehabilitative services

The regulation would amend the definition of Medicaid rehabilitative services in order to provide for important beneficiary protections such as a person-centered written rehabilitation plan and maintenance of case records. The regulation also clarifies that rehabilitation services must be coordinated with but do not include services furnished by other programs that are focused on social or educational development goals and available as part of other services or programs. These services include but are not limited to, foster care, child welfare, vocational services, and juvenile justice.

The regulation would potentially disallow "children's therapeutic intervention services" provided to children in DCS custody.

Estimated reduction in federal Medicaid funds to Tennessee over each of the next 5 years: As high as $50-60M per year if CMS defines DCS services as "rehabilitative services"

6. Payments for costs of school administrative and transportation servies

This regulation eliminates Federal Medicaid payment for certain school based administrative and transportation activities. Medicaid payments will no longer be available for administrative activities or for transportation from home to school.

TennCare does not currently claim funding for administrative services performed by school employees or contractors or for routine transportation from home to school.

Estimated reduction in federal Medicaid funds to Tennessee over each of the next 5 years: None.

7. Targeted case management

The regulation clarifies the situations where Medicaid will pay for case management activities. CMS has defined "targeted case management" to include all kinds of case management activities, including administrative case management and case management delivered in Home and Community Based Services waivers.

Tennessee has several situations that would be subject to the targeted case management regulation including children in state custody or at risk of state custody, mental health case management under the 1115 TennCare waiver, Home and Community Based Services waiver programs, and case management arrangements with DHS.

Estimated reduction in federal Medicaid funds to Tennessee over each of the next 5 years: $70M per year

Possible effect of Medicaid cuts in the State of Tennessee:

- The State could establish day and/or other limits on services provided to TennCare patients
- The TennCare MCO's could renegotiate lower rates with providers to pass along any decrease in payments from the State to the MCO's

Chairman WAXMAN. Thank you very much, Dr. Welch.
Dr. Lewis.

STATEMENT OF ROGER LEWIS, M.D., PH.D.

Dr. LEWIS. Mr. Chairman, members of the committee, thank you for inviting me. My name is Roger Lewis. I'm a professor and attending physician at the Department of Emergency Medicine at Harbor-UCLA Medical Center, and I've been working as a physician at that hospital since 1987.

Harbor-UCLA Medical Center is a publicly funded Level 1 trauma center and a teaching hospital. We're also a federally funded disaster resource center and in that capacity work with eight of the surrounding community hospitals to ensure disaster preparedness and, in the event of a disaster, an effective disaster response serving a population of approximately 2 million people. We're proud of that work and believe it is important.

Over the last 5 or 10 years my colleagues and I at Harbor-UCLA have witnessed an extraordinary increase in the demand for emergency care services of all types. We have seen an increasing volume in the number of patients who come to our emergency department and in their degree of illness and their need for care.

At the same time we've had a constant decrease in our available inpatient hospital resources and this has predictably led to a frequent occurrence of emergency department gridlock and overcrowding. Patients wait hours to be seen, ambulances carrying sick individuals are diverted to hospitals that are farther away and admitted patients in the emergency may wait hours or days for an inpatient bed.

Now I became an emergency physician because I wanted to be the kind of doctor that could treat anybody at the time of their greatest need. And similarly, my institution is proud of its work as a disaster resource center because it wants to be the kind of institution that can provide for the community as a whole in its time of greatest need.

It never occurred to me during my training that I'd be in the position in which patients that I knew clearly needed to be treated in minutes instead had to wait for hours, that ambulances carrying sick patients would be diverted to hospitals farther away, or that we would pretend that hospitals that have no available beds and a full emergency department would have adequate surge capacity to respond to the most likely type of mass casualty incidents; namely, the results of a conventional explosive. Yet that is exact the situation in which we find ourselves.

Now in trying to think about how to illustrate this situation several people suggested to me that I give an anecdote, that I tell a patient's story. And without detracting from the important examples that have been given by the other panel members, I would just like to comment that I don't think any single patient's story really captures the scope and the impact of the problem. This is the situation in which one has to think carefully about the meaning of the statistics that are widely available.

In fact, yesterday's anecdote, those stories about individuals who deteriorate in the emergency department or on the way to the hospital because their ambulance has been diverted, are really today's

norm. These events are happening every day. Right now an ambulance in this country is diverted from the closest hospital approximately once every minute.

There is a common misconception that emergency department overcrowding is caused by misuse of an emergency department by patients who have routine illnesses or could be treated in urgent care settings. This is clearly not true. Numerous studies done by nonpartisan investigators have shown that only 14 percent of patients in the emergency department have routine illnesses that can be treated elsewhere. And much more importantly, those patients use a very small fraction of the emergency department resources and virtually never require an inpatient bed.

Emergency department overcrowding is a direct result of inadequate and decreasing hospital inpatient capacity. It is a hospital problem, not an emergency department problem. There is a direct cause and effect relationship between the hospital resources, inpatient capacity, emergency department overcrowding and surge capacity.

The hospital preparedness program, a federally funded program that is intended to increase disaster preparedness, has focused on bioterrorism and on the provision of supplies and equipment for participating hospitals. And whereas these things are important, they focus on one of the less probable types of mass casualty incidents and do not in any way directly address surge capacity.

For my hospital the proposed Medicaid rules are estimated to result in a 9 percent decrease in the total funding for the institution. That would have an exponential effect on the degree of overcrowding and directly result in reductions in our inpatient capacity. For Los Angeles County as a whole the projected impact is $245 million. That would require a reduction to services equal to one acute care hospital and trauma center. We have already witnessed what happens in our area with the closure of such a hospital.

So in summary, hospitals and emergency departments across the United States increasingly function over capacity and prior fiscal pressures have resulted in a reduction in the number of inpatient beds and overcrowding. Current Federal programs intended to enhance disaster response capability have emphasized supplies and equipment and it largely ignored surge capacity.

The proposed Medicaid regulations will directly result in further reductions in hospital ED capacity and ironically specifically target the trauma centers, teaching hospitals and public institutions whose surge capacity we must maintain if they are to function at the time of a disaster.

Thank you very much, Mr. Chairman.

[The prepared statement of Dr. Lewis follows:]

Statement of

Roger J. Lewis, MD, PhD

Professor, Department of Emergency Medicine
Harbor-UCLA Medical Center
Torrance, California

before the

House Committee on Oversight and Government Reform
U.S. House of Representatives

Hearing on

"The lack of hospital emergency surge capacity: Will the Administration's Medicaid regulations make it worse? Day One"

Presented
Monday, May 05, 2008
Rayburn House Office Building

Introduction

My name is Roger J. Lewis, MD, PhD. I am an attending physician and professor in the Department of Emergency Medicine at Harbor-UCLA Medical Center, a publicly-funded, Level I Trauma Center and teaching hospital in Los Angeles County, California. I have served as a full-time supervising physician at Harbor-UCLA since 1990 and am a faculty member of the David Geffen School of Medicine at UCLA. Harbor-UCLA Medical Center serves as a regional Disaster Resource Center for the southern section of Los Angeles County. Thus, our institution would be an important provider of healthcare during a local disaster, whether natural or man made, and our staff currently work with 8 local hospitals to ensure regional disaster preparedness for a population of approximately two million people.

The Connections between Emergency Department Crowding, Surge Capacity, and Disaster Preparedness

Over the last five years, my colleagues and I have witnessed an increasing demand for emergency department (ED) and inpatient services at Harbor-UCLA, coupled with ever decreasing resources. This has led to almost continual overcrowding and gridlock in our ED while, paradoxically, we are expected to maintain our hospital's "surge capacity," defined as the ability to provide care for a large influx of patients on short notice in time of disaster. Ours is not an isolated situation but, instead, reflects the current state of emergency healthcare in the United States and a paradoxical, almost incomprehensible, lack of recognition among some policy makers regarding the cause and effect relationships that exist between the fiscal pressures that have led to decreases in hospital capacity, ED gridlock, and our dwindling surge capacity.

To those of us who work in the front lines of the medical care system, it is irrational to believe that an emergency care system that is already overwhelmed by the day-to-day volume of acutely-ill patients, would be able to expand its capacity on short notice in response to a terrorist attack or natural disaster. Moreover, any decrease in the Medicaid funding that supports the trauma center infrastructure and the funding of graduate medical education (GME) (funds which support the residents who provide the majority of care in our cornerstone academic and public healthcare institutions) will severely cripple our ability to meet the nation's needs for emergency care, whether delivered under everyday conditions or in the extraordinary setting of a mass casualty incident.

The Overcrowded Emergency Department

The demand for care in our nation's hospital emergency departments (ED) has been increasing faster than the growth of the U.S. population for years and continues to do so. According to the Centers for Disease Control and Prevention (CDC), the number of ED visits increased 26 percent from 90.3 million visits in 1993 to 114 million in 2003 but, during the same period, the number of EDs decreased by 14 percent.[1] EDs have not been able to keep up. According to Press-Ganey Associates, the average waiting time in EDs is now 3 hours and 42 minutes before an ED patient is seen by a physician.[2] A majority

of urban EDs must routinely divert ambulance traffic because of overcrowding and, for urban EDs reporting diversion, nearly one in eight is on diversion more than 20 percent of the time.[3]

Emergency department crowding is not new. I understand that this is at least the third hearing held by the Committee on Oversight and Government Reform that has addressed this issue. In 2001 *US News and World Report* published a cover story entitled, "Crisis in the ER: Turnaways and Delays are a Recipe for Disaster." In June 2006, the Institute of Medicine of the National Academies (IOM) released a three volume report on the future of emergency care in the United States. The IOM reviewed more than 4,300 published studies, 11 commissioned reports, and heard testimony from 62 experts. After weighing this vast body of evidence, the IOM concluded that trauma and emergency care in the U.S. is at the "breaking point."

Despite the current and increasing need for emergency care, we continue to lose EDs with a resulting reduction in our total ED capacity. In my home state of California, according to the California Medical Association, 75 California EDs have closed since 1991, a loss of 11 percent.[4] Closures have been attributed to high numbers of uninsured patients (20 percent of California residents lack health coverage), low Medicaid reimbursement rates, unfunded mandates requiring hospitals to meet nurse-to-patient staffing ratios, and structural retrofitting to meet current seismic standards (expected to cost $24 billion).[4,5]

Nationwide, the current state of ED crowding was assessed in a simultaneous survey of 250 EDs conducted in 2001. This survey found that 22 percent of ED patients were already admitted but were boarded in the ED and waiting for an inpatient bed; 38 percent of ED directors reported doubling up patients in exam rooms, and 59 percent reported using hallways as patient care areas.[6] Due to ED crowding, an estimated 500,000 ambulance transports are diverted annually from EDs that are full and sent to more distant hospitals.[7,8]

At a fundamental level, ED overcrowding represents an imbalance between the need for emergency medical care and hospitalization, and the available capacity in the healthcare system. This imbalance is the result of a "perfect storm," consisting of rapid and steady increases in ED visits noted above, combined with simultaneous reductions in the number of EDs and especially the number of inpatient hospital beds. The available number of inpatient hospital beds determines, to a large extent, how quickly a patient who requires hospitalization can be moved out of the ED, both so they receive care in a more comfortable setting, and so their space in the ED can be used for the care of a new patient.

Why have the numbers of EDs and hospital beds decreased? Reductions in reimbursement from Medicare, Medicaid and other payers, as well as payment denials, have markedly reduced hospital resources. Another driving factor in the hospital resource equation is the escalating cost of pharmaceuticals, medical supplies and personnel. Finally, the most remarkable factor for both public and private hospitals alike,

is the increasing numbers of uninsured ED visits which are reflected in reports of the California Hospital Association citing that over 50 percent of California EDs are "running in the red." To survive financially, hospitals have been forced to operate with far fewer inpatient beds than previously. Specifically, between 1993 and 2003, the number of inpatient beds declined by 198,000 (17 percent).

The overall result is that fewer inpatient beds are available for an increasing number of emergency patients who are admitted to the hospital. Without available inpatient beds, many admitted patients are "boarded," remaining in the ED while waiting for an inpatient bed. Some patients even wait in non-clinical spaces, including hallways, offices, storerooms, and conference rooms.

There is a common misconception that ED overcrowding is caused by patients seeking treatment for non-urgent care. This is clearly untrue. According to the latest CDC ED data, less than 14 percent of all ED visits are classified as "non-urgent," meaning the patient needed to be treated within 24 hours. Overall, almost 70 percent of the patients arriving at the ED need to be seen within two hours and 15 percent of those patients need to be seen within 15 minutes.

Another consequence of ED overcrowding is ambulance diversion, a request by the hospital to redirect 911 traffic to the next available ED. Importantly, ambulances are only diverted to other hospitals when crowding is so severe that patient safety would be jeopardized if another patient were brought to the overcrowded ED. The GAO has reported that two-thirds of EDs diverted ambulances to other hospitals during 2001, with crowding most severe in large population centers where nearly one in 10 hospitals reported being on diversion 20 percent of the time (more than four hours per day).

A study released by the National Center for Health Statistics found that, on average, an ambulance in the United States is diverted from a hospital every minute because of ED overcrowding or bed shortages. This national study, based on 2003 data, reported air and ground ambulances brought in about 14 percent of all ED patients, with about 16.2 million patients arriving by ambulance. Of these over 16 million patients, 70 percent had urgent conditions that required care within an hour. A companion study found ambulance diversions in Los Angeles more than tripled between 1998 and 2004. During the last several months, our hospital has had to divert ambulance traffic more than half the time.

According to the American Hospital Association (AHA), nearly half of all hospitals (46 percent) reported time on diversion in 2004, with 68 percent of teaching hospitals and 69 percent of urban hospitals reporting time on diversion.

As you know, the Committee on Oversight and Government Reform conducted an "Emergency Care Capacity Survey" in March 2008. Before I describe my hospital's response to that survey, I would like to point out that Harbor-UCLA Medical Center provides acute care and trauma services to a catchment area of over 2 million individuals.

We have over 60 treatment beds in the ED and usually have a census of over 350 acutely-ill patients admitted in the hospital.

Despite this structural capacity, my hospital is frequently overwhelmed with demands for care. For example, on the weekday afternoon that the Committee's survey was conducted (4:30 pm on March 25, 2008), there were 78 patients undergoing treatment in the ED. Because we don't have room for that number of patients, 33 were being treated in chairs or hallways not originally intended for patient care, 37 patients were still in the waiting room waiting to be seen by a physician, and 20 patients we had previously admitted to the hospital were being "boarded" in the ED because there was no room in the inpatient hospital wards. Some of our admitted patients had been waiting one or two full days for a bed upstairs. Not surprisingly, the ED was on ambulance diversion because we had no space for incoming ambulance patients.

The situation we reported on March 25th is typical. During the week preceding the survey, our ED was on diversion for over 100 hours (more than four full days out of the week). It is difficult to claim that my hospital's Level I trauma center has any appreciable "surge capacity" when our hospital routinely functions at greater than 100 percent capacity, the ED waiting times are often greater than 24 hours, and the number of boarded admitted patients in the ED often comprise the majority of patients in the clinical care area. Our adult ED diversion rates (the fraction of the time ambulances were diverted) for January, February, and March of 2008 were 58 percent, 60 percent, and 55 percent, respectively.

The emergency care system across Los Angeles County experiences predictable periodic increases in demand, for example, during seasonal outbreaks of influenza. According to Cathy Chidester, Director of the LA County Emergency Medical Services (EMS) Agency, during this past winter, EDs across Los Angeles and Orange Counties reported an increase in patients presenting with seasonal respiratory illnesses, which put a strain on our local emergency medical services system. In Los Angeles County, the rate ambulances were turned away from hospitals due to ED overcrowding increased from an average of 12 percent in December to 28 percent in February. Patient wait times of 4-6 hours were reported. In Orange County, EDs were saturated for a total of 1,663 hours in February compared to 1,058 hours during the same month last year. This is equivalent to two hospital EDs being saturated and unavailable to ambulance patients for the whole month.

Despite the increasing demands for emergency care and the associated needs for additional capacity, the imbalance between capacity and demand is growing worse. In Los Angeles County in the last five years, ten EDs have closed. In most cases, the hospitals associated with these EDs have closed as well, including one major public hospital and other hospitals have continued to reduce their inpatient capacity.

Medicaid Funding, Trauma Centers, Teaching Hospitals, and Disaster Preparedness

Unfortunately, a policy initiative currently being pursued by the Centers for Medicare and Medicaid Services (CMS) could make matters much worse. Two proposed rules, CMS 2258 and CMS 2279, would severely harm hospitals that serve as the cornerstones of our nation's remaining trauma and emergency care capacity by pulling nearly $4 billion in federal funds from them. Many of the affected institutions anchor the trauma and disaster response systems of our nation's largest cities.

The supplemental Medicaid payments which CMS 2258 will eliminate are vital to the ongoing operation of these hospitals. Level I trauma centers—the largest and most sophisticated—typically care for the most complex and costly patients. Although anyone, rich or poor, can become a trauma victim, a disproportionate number are uninsured. This makes hospitals that focus on trauma, emergency and disaster care highly dependent on public funds, because insurance revenue alone is insufficient to cover their costs.

Graduate medical education (GME) funding—whether provided by Medicare, Medicaid, or both, is another vital source of revenue for these hospitals. CMS 2279 will eliminate it. GME funding provides teaching hospitals with a revenue stream to cover the salaries of hardworking physicians-in-training. These doctors provide their communities, in turn, with vital services in such areas as trauma, burn and emergency care.

The Los Angeles County Department of Health Services (LACDHS) operates the nation's second largest local public hospital system, and serves as the primary healthcare provider to the County's uninsured and indigent residents. LACDHS provides medical care to nearly 700,000 individual patients and is responsible for approximately 2.5 million outpatient visits each year. Its hospitals train 40 percent of all medical residents in the County, and provide 36 percent of all trauma care and 10 percent of all emergency room visits in the County.

Medicaid is, by far, the single largest source of revenue for public hospitals, including those in Los Angeles County. In recognition of their key role in providing medical care to the indigent and uninsured as well as to Medicaid recipients, public hospitals are allowed to receive Medicaid payments that exceed the cost of medical care provided to Medicaid recipients. In addition, public hospitals provide critical high cost services, such as trauma, neo-natal, HIV/AIDS, and burn care. All teaching hospitals, including the County's public hospitals, also have been allowed to claim Medicaid reimbursement of GME costs in recognition of essential medical care provided by residents and interns to Medicaid patients.

On January 18, 2007, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule to limit Medicaid payments to government providers to no more than the cost of providing services to Medicaid recipients, and, on May 23, 2007, CMS issued a proposed rule to eliminate Medicaid reimbursement of GME costs. The County opposes both proposed rules on the grounds that the proposed rules would greatly reduce

Medicaid funding for safety net hospitals, endangering the patients and communities served by them.

If implemented, both regulations would result in an estimated total combined annual Medicaid revenue loss of $240 million to LACDHS-- $200 million from the cap on Medicaid payments to public hospitals and $40 million from the elimination of Medicaid reimbursement of GME costs. This is on top of a projected fiscal year 2008-09 budgetary shortfall of $198 million, which is expected to multiply in the following four years to a cumulative $1.4 billion by fiscal year 2011-12. The Director of the Department of Health Services has estimated that the implementation of these regulations would require significant reductions in hospital-based or outpatient services equivalent to the closure of one of our major teaching hospitals--including its ED and trauma center--a potential loss of some 90,000 ED visits annually.

In response to the recent survey conducted by this Committee, the administration of Harbor-UCLA Medical Center estimated that the proposed Medicaid regulations would result in a loss of over $50 million in annual funding, representing over 9 percent of our total budget. Such a cut in funding would directly result in a reduction of inpatient and ED capacity, as well as virtually eliminating any surge capacity that still exists.

Because Harbor-UCLA Medical Center is both a teaching hospital and a trauma center, we have a substantially higher number of physicians on site at any time, compared to a non-teaching community hospital, primarily consisting of interns and residents completing their specialty and subspecialty training. This level of staffing, which can only be maintained through the federal support of GME, is a key feature which allows us to cope to some extent with the overwhelming demands for healthcare, and is a key component of our remaining ability to respond to a mass casualty incident. More broadly, any loss of funding for GME across the US would directly reduce the physician manpower available at the trauma centers and teaching hospitals that form the foundation of hospital-based disaster response in many communities.

Our Investment in Disaster Preparedness

Since the attacks of September 11, 2001, substantial resources have been devoted to improving disaster preparedness in the United States, with an emphasis on mitigating terrorist threats. Adequate preparedness can only be achieved with a comprehensive approach that connects local, state and federal programs. At the local level, planning should include all critical providers of disaster healthcare resources including hospitals, clinics, nursing homes, alternate care facilities, public health departments, and EMS systems.[9] While hospitals are only one component of a regional program for disaster management, they represent a critical link in the system. In 2002, the U.S. Department of Health and Human Services (HHS) Health Resources and Services Administration (HRSA) established the National Bioterrorism Hospital Preparedness Program (NBHPP)[10] with an explicit goal to improve the preparedness of hospitals for bioterrorism. The program's priorities included improving hospital surge capacity, decontamination capability, and isolation capacity, as well as supplementing

pharmaceutical supplies, and supporting training and education.[11] When President Bush reauthorized the Pandemic and All Hazards Preparedness Act (Public Law 109-417) in 2006, oversight of the NBHPP was moved from HRSA to the Assistant Secretary of Preparedness and Response, and the NBHPP was renamed the Hospital Preparedness Program (HPP).[11]

Efforts to enhance hospital preparedness have appropriately focused on improving "surge capacity," defined by the American College of Emergency Physicians as the "healthcare system's ability to manage a sudden or rapidly progressive influx of patients within the currently available resources at a given point in time."[12] Surge capacity is influenced by three essential elements: staff, supplies and equipment, and structure.[13,14]

In 2006, the federal government granted $474,210,000 to be used by HPP recipients to improve communication systems, to network among community stakeholders, conduct training, and stockpile supplies and equipment.[15] An example of just some of the items that were expected to be purchased by the awardees with these funds include: medical-surgical supplies; specialized personal protective equipment (Level C); mobile decontamination trailers; ventilators; HEPA filters; pharmaceuticals; such as antidotes to nerve agent exposure and antibiotics; water; portable generators; evacuation chairs and sleds; portable monitors, fluid warmers, tents, tables, cots, chairs, lights, heaters, hand-washing sinks, and toilets; storage trailers; walkie-talkies, a call-back system; body bags, and a fully-loaded truck. The recommendation was that all of these items should be readily deployable to any disaster site at a moment's notice.

Many of the items required by the HPP program would only be needed in time of biological or chemical attack. Our nation needs a balanced and logical approach to terrorism preparedness; one focused on the most likely terrorist threat—explosive devices. Rather than strengthening our nation's capacity to respond to the most likely mass casualty events, including terrorist bombings, we have directed the vast amount of preparedness resources and energy into efforts to develop biological countermeasures against bioterrorism. By one estimate, the federal government has spent more than $32 billion to date on biodefense.

Faced with many of the same enemies and threats, our allies have identified different priorities for terrorism preparedness. In February, 2007, Kobi Peleg, PhD, MPH, Director of Israel's National Center for Trauma and Emergency Medicine Research, Co-chair of the master program for emergency and disasters management in Tel-Aviv University, and one of the world's leading experts on terror-related mass casualty events, gave a briefing for Hill staff entitled "Dealing with Terror MCI [Mass Casualty Incidents] Lessons Learned from the Israeli Experience." Over the course of his presentation, Dr. Peleg described several ways Israel's approach differs from that of the United States. Notably, because Israeli EDs must always be prepared to absorb a sudden influx of victims, they are never allowed to become gridlocked. If an ED becomes crowded, admitted patients are promptly moved to inpatient units, even inpatient hallways if necessary.

Acquisition and Stockpiling of Supplies and Equipment Does Little to Create Surge Capacity

Unfortunately, while the acquisition of supplies, equipment, and pharmaceuticals is a necessary step towards preparedness, it is not sufficient to ensure adequate hospital surge capacity. Simply stockpiling materials fails to address important existing deficiencies in the US healthcare system that limits an effective disaster response.

"Disasters are local" is a basic tenet of preparedness, as the initial response to a disaster always begins at the local level. Yet, local hospital capacity has diminished markedly over the past 20 years. According to an AHA 2007 survey, the majority of US hospitals routinely function at greater than 100 percent capacity.[3]

The lack of hospital surge capacity must be addressed to improve disaster preparedness. Stockpiled supplies and written plans are of little use without sufficient available ED capacity and inpatient hospital capacity. While the current focus on tangible and measurable parameters is well intentioned, a strategy based on stockpiling alone as an effective disaster preparedness strategy is misguided. In the aftermath of a catastrophic disaster, effective use of stockpiled supplies, pharmaceutical agents, and equipment also requires adequate available patient care space and qualified personnel.[16]

On June 22, 2007, the House Committee on Oversight and Government Reform held a hearing on The Government's Response to the National Emergency Care Crisis. At this hearing, three national experts on emergency care—a trauma surgeon, an emergency physician, and an EMS Medical Director—testified that our nation is not prepared to handle a major terrorist bombing, much less a major natural disaster or flu pandemic. When asked if HHS' Hospital Bioterrorism Preparedness Program (which has disbursed more than $2.7 billion in federal funds to the states) has produced any discernable improvement in the emergency care crisis, all three experts answered "no".

Closing Summary

In summary, hospitals and EDs across the U.S. increasingly function at or above their designed capacity. Prior fiscal pressures have encouraged reductions in the number of inpatient beds and discouraged the creation and maintenance of hospital surge capacity. Simultaneously, the demand for emergency medical care has increased, leading to overcrowded EDs, full hospitals, and a marked reduction in disaster surge capacity. Although ED closures and the downsizing of hospitals are logical strategies for improving fiscal efficiency, these efforts to decrease healthcare costs run counter to simultaneous efforts to maintain disaster response capability.

Current federal programs intended to enhance the disaster response capability of hospitals have emphasized the acquisition of supplies and equipment, focused on relatively unlikely threats, and largely ignored the real limitations of an overwhelmed and crumbling emergency care infrastructure.

The proposed Medicaid regulations will directly result in further reductions in hospital and ED capacity and, ironically, specifically target trauma centers and teaching hospitals—the very institutions whose surge capacity we must maintain if they are to function in the time of disaster or terrorist attack.

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COMMENTARY

Current Hospital Disaster Preparedness

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SINCE THE ATTACKS OF SEPTEMBER 11, 2001, SUBSTANtial resources have been devoted to improving disaster preparedness in the United States, with an emphasis on mitigating terrorist threats. Adequate preparedness can only be achieved with a comprehensive approach that connects local, state, and federal programs. At the local level, planning should include all critical disaster health care resources, including hospitals, clinics, nursing homes, alternate care facilities, public health departments, and emergency medical services systems.[1]

Although hospitals are only one component of a regional program for disaster management, they represent a critical link in the system. In 2002, the US Department of Health and Human Services Health Resources and Services Administration (HRSA) established the National Bioterrorism Hospital Preparedness Program (NBHPP)[2] to improve the preparedness of hospitals. The program's priorities included improving hospital surge capacity, decontamination capability, and isolation capacity, as well as supplementing pharmaceutical supplies, and supporting training and education.[3] When President Bush reauthorized the Pandemic and All Hazards Preparedness Act (Pub L No. 109-417) in 2006, oversight of the NBHPP was moved from HRSA to the Assistant Secretary of Preparedness and Response, and the NBHPP was renamed the Hospital Preparedness Program (HPP).[3]

Hospital Disaster Preparedness Efforts

Efforts to enhance hospital preparedness have appropriately focused on improving surge capacity, defined by the American College of Emergency Physicians as the "healthcare system's ability to manage a sudden or rapidly progressive influx of patients within the currently available resources at a given point in time."[4] Surge capacity is influenced by 3 essential elements: staff, supplies and equipment, and structure.[5,6] Structure refers to both the location for patient care and the organizational infrastructure, such as the hospital incident command system.

The HPP benchmarks for surge capacity include the ability to care for 500 patients per 1 million for infectious disease events and 50 patients per 1 million for other mass casualty incidents.[3] These recommended surge benchmarks are based on expert opinion rather than a quantitative probabilistic assessment of risk,[3] and valid methods for measuring preparedness are lacking. This makes it difficult to assess the adequacy or effectiveness of interventions aiming to improve preparedness.[6] Surge planning is further complicated by the diversity of potential hazard types and by the inability to predict the number of victims or severity of injuries.

In 2006, the federal government granted $474 210 000 for HPP recipients to improve communication systems, network among community stakeholders, conduct training, and to stockpile supplies and equipment.[7] Among other items, awardees were required to purchase medical-surgical supplies, personal protective equipment, mobile decontamination trailers, ventilators, high-efficiency particulate air filters, pharmaceutical agents (including antidotes to nerve agent and antibiotics), water, portable generators, evacuation equipment, monitors, fluid warmers, tents, tables, cots, chairs, lights, heaters, hand-washing sinks, ultrasound machines, toilets, walkie-talkies, and an automated call-back notification system.[7]

The acquisition of supplies, equipment, and pharmaceuticals is a necessary step toward preparedness but is not sufficient to ensure adequate hospital surge capacity. Simply stockpiling materials fails to address important existing deficiencies in the US health care system that limit an effective disaster response.

Diminished Local Hospital Capacity

"Disasters are local" is a basic tenet of preparedness, because the initial response to a disaster always begins at the local level. State or federal resources can only be requested once local and regional resources are exceeded. However, local hospital capacity has diminished markedly during the past 20 years. According to an American Hospital Association 2007 survey, the majority of US hospitals routinely function at more than 100% capacity.[8] The nationwide nursing shortage also limits hospital surge capacity and, as of December 2006, hospitals had an estimated 116 000 nurse vacancies.[8]

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The demand on hospital emergency departments (EDs) is increasing. According to the Centers for Disease Control and Prevention, the number of ED visits increased 26% (90.3 million visits in 1993 to 114 million in 2003), but during the same period the number of EDs decreased by 14%.[9] According to Press Ganey Associates, the average waiting time is 3 hours 42 minutes before a patient in the ED is seen by a physician.[10] A majority of urban EDs routinely divert ambulance traffic and, for urban EDs reporting diversion, approximately 1 in 8 is on diversion more than 20% of the time.[8] According to the American Hospital Association survey, the lack of nurse-staffed critical care beds is the leading reason for ED diversion.[8] Approximately 55% of community EDs have gaps in physician specialty coverage, particularly in orthopedics and neurosurgery,[8] likely due to limited reimbursement for ED services and the additional liability associated with caring for patients in the ED.

According to the California Medical Association, 75 California EDs have closed since 1991, a loss of 11%.[11] Closures have been attributed to high numbers of uninsured patients (20% of California residents lack health coverage), low Medicaid reimbursement rates, unfunded mandates requiring hospitals to meet nurse-to-patient staffing ratios, and structural retrofitting to meet seismic standards (expected to cost $24 billion).[11,12] In Los Angeles County during the last 5 years, 10 EDs have closed, 1 major public hospital has closed its trauma services, and other hospitals have continually downsized.

In an assessment of ED crowding based on a national simultaneous survey of 250 EDs conducted in 2001, 22% of patients in the ED were already admitted but were boarded in the ED and waiting for an inpatient bed, 38% of ED directors reported doubling up patients in examination rooms, and 59% of ED directors reported using hallways as patient care areas.[13] Due to ED crowding, an estimated 500 000 ambulance transports annually are diverted from EDs that are full and sent to more distant hospitals.[14,15]

The Emergency Medical Treatment and Active Labor Act (EMTALA), a national mandate passed in 1986 to help ensure access to emergency care, ironically may have indirectly reduced surge capacity and access to care. The EMTALA requires hospital EDs and hospital-based ambulance services to provide a medical screening examination and emergency care to anyone requesting treatment, regardless of citizenship, legal status, or ability to pay.[16] Although guaranteed access to ED care, the uninsured are less likely to seek care unless severely ill,[17] thus increasing the acuity of these patients in the ED compared with those with insurance. These patients contribute to higher ED costs, as well as higher inpatient admission rates, even as the number of hospital beds is decreasing.[14] When the medical bills of the uninsured are unpaid, hospitals are forced to absorb the costs, reduce other expenses, or risk bankruptcy. One strategy for eliminating this financial drain is to close hospital EDs or convert them to urgent care facilities that fall outside the scope of EMTALA. This is one factor contributing to the reduction in the number of EDs across the country.

Improving Preparedness and Surge Capacity

The lack of hospital surge capacity must be addressed to improve disaster preparedness. Stockpiled supplies and written plans are of little use without sufficient available ED capacity and inpatient hospital capacity. Although the current focus on tangible and measurable parameters is well intentioned, a strategy based on stockpiling alone as an effective disaster preparedness strategy is misguided. In the aftermath of a catastrophic disaster, effective use of stockpiled supplies, pharmaceutical agents, and equipment also requires adequate patient care space and qualified personnel.[18]

Tangible steps can be taken at the local level to enhance surge capacity to some extent and do not require building new hospitals or expanding existing ones. Hospitals constitute only one part of a larger community. By working with other community organizations such as schools and churches, hospital personnel can identify alternate sites for patient treatment and storage of equipment and supplies. Neighboring hospitals may work together to enhance regional health care surge capacity by developing mutual aid agreements for patient transfers and for the sharing of personnel, equipment, and supplies.[19] For example, a community hospital may agree to accept medical patients from an overwhelmed regional trauma center so the trauma center can care for additional patients with trauma. Hospitals may also work together to estimate their collective surge capacity, sharing information about each hospital's bed capacity, staffing, and equipment stockpiles. If the resulting estimate of community-wide surge capacity is found to be insufficient, a credible request for more resources from state and federal governments can be made.

Additional steps that can be taken locally include developing plans and procedures to address staff needs (dependent care), ensure security by working with local law enforcement to control ingress and egress,[19] and expand morgue capacity (such as having agreements with refrigerated trucks and mortuary support). Plans for staffing during a significant surge event can be developed using employee callback protocols, as well as procedures for immediately credentialing medical and nonmedical volunteers from other hospitals.[20]

During a mass casualty event, the least serious casualties generally arrive at the hospital first and hospital personnel are often unaware that more serious patients are yet to arrive. To maximize the effective capacity of the hospital, staff should be instructed to expect the arrival of more serious casualties and to avoid filling existing beds with minor injuries.[19]

Although optimizing local surge capacity is paramount, lack of hospital capacity is a pervasive national problem and finding comprehensive solutions will require leadership and funding at the federal level. The formation of the US De-

partment of Homeland Security was the largest government transformation since the formation of the Department of Defense after World War II.[21] One goal of the Department of Homeland Security is to integrate efforts across multiple levels of government by endorsing the National Incident Management System and the National Response Plan.[22] The HPP, under the auspices of the US Department of Health and Human Services, is a logical programmatic structure for enhancing hospital preparedness.

Achieving sufficient surge capacity will be difficult in the face of real and ongoing daily deficiencies in the national health care system, independent of any particular disaster scenario—the nursing shortage, the closure of hospitals and EDs, and the lack of access to both primary and specialty care. It is also unrealistic to expect the private health care sector to create standing surge capacity given the current structure of financial incentives and reimbursements. Although fiscal pressures often appropriately motivate the downsizing of hospitals and the alignment of capacity with average demand, these fiscal forces should not completely eclipse the importance of maintaining surge capacity (staffed hospital beds are a critical aspect of surge capacity) and thereby preparedness. For example, federally funded incentives could be paid to hospitals that maintain given levels of surge capacity, with additional incentives to those that meet HPP benchmarks.

The nursing shortage also must be addressed, beginning with expanding faculty for nursing education. According to a 2006-2007 American Association of Colleges of Nursing report, US nursing schools turned away 42 866 qualified applicants from baccalaureate and graduate nursing programs in 2006 due to insufficient faculty and preceptors, classroom space, and budget constraints.[23] Seventy-one percent of the nursing schools responding to a 2006 survey pointed to faculty shortages as a reason for not accepting all qualified applicants into nursing programs.[23] Policy makers should seek innovative ways to attract and keep nurse educators, such as providing instructors with compensation levels that rival salaries offered in the private sector.[23-25]

In conclusion, many hospitals and EDs function at or above their designed capacity and fiscal pressures discourage the creation and maintenance of hospital surge capacity. Although ED closures and downsizing of hospitals are logical strategies for improving efficiency, these efforts to decrease health care costs run counter to simultaneous efforts to enhance or maintain surge capacity. These opposing considerations must be programmatically reconciled to achieve meaningful preparedness. At a local level, hospitals and their surrounding communities should be encouraged to implement strategies to expand effective capacity. However, substantial enhancements to hospital and surge capacity will require an effective and appropriately funded national strategy to address hospital and ED crowding.

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Chairman WAXMAN. Thank you very much, Dr. Lewis.
Dr. Kaplowitz.

STATEMENT OF LISA KAPLOWITZ, M.D.

Dr. KAPLOWITZ. Good morning Mr. Chairman, members of the committee. I'm Lisa Kaplowitz. I'm deputy commissioner for emergency preparedness and response for Virginia Department of Health. In that role, I'm responsible for both the public health and health care response to any emergency. And we take a very all-hazards approach to emergencies in Virginia.

Virginia is large and diverse and has been impacted by any number of emergencies since 9/11. Certainly we were impacted by the Pentagon, which is located within Arlington County, but we have experienced the anthrax attack, sniper episode, Virginia Tech and multiple weather emergencies.

A few lessons from 9/11. First of all, this truly was a mass fatality event, not really a mass casualty event. But we certainly have learned that one key to response is coordination of all the health care facilities in the area, cross borders in the national capital region; that's Virginia, Washington, DC, and Maryland. And we all need to work together, both in the NCR and throughout the Commonwealth. We knew we needed a much improved communication system among health care facilities and with public health communications really was inadequate during 9/11. We had no back-up communications present. We needed a mass fatality plan, and we needed to include mental health planning in all emergency planning.

The Congress allocated funds for both public health and health care preparedness as a result of 9/11 and anthrax. I won't spend a lot of time on the public health preparedness—I'm responsible for that—except to mention that we have coordinated our public health and health care response. They work very closely together.

In terms of our health care system preparedness, the key to our success has been partnership with the hospital association which contracts with hospitals throughout the Commonwealth, and we got buy-in from the hospitals very quickly. We also do regional planning. We have three hospital planning regions, a hospital coordinator and a regional coordinating center for each of our regions.

The funding from ASPR has been very, very valuable. It's enabled us to purchase redundant communication systems for hospitals, to develop a statewide Web based tracking system. We can now track beds in a realtime basis throughout the Commonwealth during any emergency. We've purchased supplies and equipment often done on a regional or statewide basis. This has included portable facilities that are located in four regions of the Commonwealth and can be moved all around. We've purchased ventilators that are the same ventilators statewide that are being used in hospitals so people know how to use them. We've purchased over 300 ventilators for use in a surge. We've purchased antivirals and antibiotic medication located in hospitals. And we've developed a volunteer management system.

Before I move on to trauma and burn care systems, I do want to say that the ASPR funds are very valuable but are only a fraction of hospital funding for emergency response. The trauma sys-

tem in Virginia was established in 1980. We now have five Level 1 trauma centers, three Level 2 and five Level 3 centers in the Commonwealth. We have three burn centers, for a total of 37 burn beds within the Commonwealth.

Our general assembly did a study in 2004 documenting a large amount of unreimbursed trauma care. In 2003, it amounted to over $44 million, and I know it's vastly greater than that 5 years later. As a result of this study, the general assembly did create a trauma fund which helps with our reimbursed care but, again, only provides a fraction of unreimbursed care. It's based on fees for reinstatement of driver's license and DUI violations.

I do want to talk a little bit about lessons learned from Virginia Tech. Nobody expected to have a shooting event, a mass shooting event in rural Virginia, such as occurred a year ago. What many people don't realize is that, because of the winds and the snow, none of the injured could be transported to a Level 1 trauma center or even a Level 2 trauma center. The three closest hospitals, two were Level 3 trauma centers; one was not a designated trauma center. We had planned for this, recognizing that all facilities need the capability of handling trauma care. And we're very proud of the fact that none of the injured transported to hospitals from Norris Hall died. That's due to our coordination of EMS, as well as hospitals, public health and our regional coordinating center. So some of our lessons learned from Virginia Tech concerning mass trauma include the need for coordination of all parts of public health in the health care system.

Cross training is key. This has been mentioned already. In a mass casualty event, all facilities need to be able to handle trauma care. That not only involves supplies but training of staff in all facilities. We have purchased supplies for all facilities in the Commonwealth to handle a certain level of trauma and burn care. We know that burn care will be key here, and we want all facilities to be able to handle that. And we need a real time patient tracking system which didn't exist, and we're working very closely on that now so that patients can be tracked from the time EMS picks them up until the time they're in the hospital and, unfortunately, for our chief medical examiner as well. We're very fortunate to have a very strong Medical Examiner's Office because this was a crime scene and had to be handled as a crime scene, and they handled it very well.

We need to recognize that at any mass casualty event, there will be fatalities. So, in terms of trauma surge planning in Virginia, we've focused on a number of different aspects here: Again, as I mentioned, purchase of key supplies and medications for burn and trauma care in all facilities, and this has been very basic, looking at basic supplies to be stockpiled.

Training of physicians and staff in all hospitals to provide basic trauma and burn care, because we don't know where trauma is going to occur, and we'll need the help of all our facilities.

Training of EMS and hospital staff on appropriate triage. Unfortunately, during a mass casualty event, we won't have the luxury of transporting people to solely our trauma centers. But we're very dependent on these centers to have the expertise that they can then use to train others.

And we need mass fatality planning as a component of mass casualty planning.

I was asked to make a few comments about our recent tornadoes. We were fortunate; nobody died as a result of those tornadoes, and there were only three serious injuries. But I will say that there was excellent communication among the hospitals in the area. Once again, this was a very rural area. They communicated well. We called on our medical reserve corps to help. Our public health folks were available immediately and are working in the area now. So our planning has really paid off there.

A few comments in summary. Hospital and health system emergency preparedness can be achieved only through close collaboration and regional planning efforts for public health and health care. There must be a system prepared to respond, especially for mass casualty and fatality events. Preparedness is tested not only through exercises but through actual events. We do an after-action report for every single event and take our lessons learned to modify our plans. A coordinated trauma system is essential, but we have to have a well thought out trauma and health care surge plan to effectively respond to large-scale events. Trauma care provided only through designated trauma centers will not be adequate, but we need those centers as resources to train others.

We desperately need continued Federal funding for public health and health care preparedness. Our CDC and ASPR funds have been very valuable, but I need to point out that it's only a fraction of the moneys used for preparedness. It's a relatively small amount in the Commonwealth. It doesn't even come close to covering, for example, unreimbursed care, and it's not for operational funding. But it has been very valuable, and I plead with you not to have further cuts in either CDC or ASPR funding. Thank you again for the opportunity to share Virginia's plans, challenges and accomplishments, and I'll be glad to answer questions.

[The prepared statement of Dr. Kaplowitz follows:]

Hospital and Health System Emergency Preparedness and Response in Virginia: Lessons from the Past and Challenges for the Future

Lisa G. Kaplowitz, MD, MSHA
Deputy Commissioner, Emergency Preparedness and Response
Virginia Department of Health

Testimony to House Committee on Oversight and Government Reform
May 5, 2008

Introduction:

Mr. Chairman and members of the Committee, I am Dr. Lisa Kaplowitz, Deputy Commissioner for Emergency Preparedness and Response for the Virginia Department of Health, a position I have held since August, 2002. In this position, I am responsible for the public health and healthcare response for all emergencies in Virginia. This includes responsibility for both the CDC Public Health Preparedness and HHS/ASPR Hospital and Healthcare Preparedness funding to the Commonwealth.

Virginia Information and Lessons Learned from 9-11, sniper events of 2002

Virginia is a large and diverse state which includes large urban areas and very rural areas, costal and mountainous regions, affluent and economically depressed areas, and a very culturally diverse population. While many have focused on the vulnerability of large urban areas to terrorism attacks, we know that mass trauma can impact rural areas in the wake of the Virginia Tech tragedy just over a year ago, and the severe weather events of last week. Consequently, the Emergency Preparedness and Response (EP&R) Program of the Virginia Department of Health (VDH) has spent the past 6 years working to assure that every part of the Commonwealth is prepared to handle the public health and healthcare response to all emergency events. Because Northern Virginia is an integral part of the National Capital Region (NCR) with about 47% of the NCR population (2005), we have also worked extensively with Washington DC and Maryland on public health and healthcare emergency planning, including participating in multiple joint exercises. In addition, Virginia has collaborated with all other adjoining states, North Carolina, West Virginia, Tennessee and Kentucky, on joint planning and exercises.

Virginia was one of the sites at the epicenter of the events of 9-11, as well as the subsequent anthrax events of 2001 and the sniper attacks of 2002. The Pentagon is surrounded by Arlington County, Virginia and the Incident Commander for that 9-11 event was the Arlington Deputy Fire Chief. Unfortunately, the Pentagon plane crash was more a mass fatality event than a mass casualty event. While hospitals in Northern Virginia and Washington DC were able to coordinate efforts to care for the casualties on September 11, 2001, there were a number of important Lessons Learned from the Pentagon event, as well as the sniper event that followed not long after; key among these were:

1. **The need for vastly improved communications among healthcare facilities and among hospitals, public health and first responders.** At the time of 9-11, hospitals in Virginia had no communication link to local or state Emergency Operations Centers (EOCs), or to public health at local or state levels. Communications among hospitals in both the NCR and throughout Virginia were poor and information spread by rumor. For example, there were rumors at the VCU Health System in Richmond (where I worked at the time) that burn and trauma patients were en route from Northern Virginia and the hospital cancelled

all elective surgery and activated emergency plans. No patients were ever transferred and the hospital incurred significant unnecessary financial loss.
2. **Back-up emergency communications for hospitals were inadequate.**
3. **There was a need for mass fatality planning. The Pentagon crash was more a mass fatality event than a mass casualty event.** Any crash, explosive or shooting event is likely to result in fatalities, including mass fatalities. There was uncertainty of how to proceed with the fatalities before the responsibility was assigned to the Virginia Chief Medical Examiner, who was extremely knowledgeable about handling fatalities in a crime scene.
4. **The need to include mental health emergency planning in all healthcare emergency planning.** For both the Pentagon crash and the sniper event of 2002, the mental health impact lasted far longer than the time to address the physical impact, requiring community support services for 18-24 months after the events.

Regional planning and HRSA/ASPR grant, plus coordination between public health and healthcare communities, in Virginia:

As part of the response to the lessons of 9-11 and the anthrax incidents of 2001, Congress passed legislation and allocated significant funds to build and enhance emergency preparedness for both the public health and healthcare systems. Virginia received significant funding for public health preparedness from the CDC and hospital preparedness from HHS/HRSA in 2002; my position was created to assume responsibility for both funding sources and to build a coordinated public health and healthcare emergency preparedness and response system in Virginia. There have been a few key factors responsible for the success of this effort in the Commonwealth:

1. **High level support for this effort from Governor Warner, continued by Governor Kaine, and the Commissioner of Health, Dr. Robert Stroube.** This support enabled me to rapidly fill program positions with VDH and the state laboratory, resulting in rapid initiation of planning and response activities.
2. **Partnership with the Virginia Hospital and Healthcare Association (VHHA)** that predated receipt of federal funding, resulting in rapid support and buy-in from all acute care hospitals statewide.
3. **Agreement of hospitals, working through VHHA, to regional planning for both emergency planning and response activities**, including sharing of key information, plus statewide and regional purchase of supplies and equipment.
4. **Close collaboration between public health and healthcare facilities** (hospitals and long term care facilities) at both state and local levels.

Virginia has a unified public health system, which has been an asset for development of a coordinated public health response. The population of the Commonwealth is served by 35 District Health Departments that cover the entire state and are responsible for providing all public health services at the local level. While the Districts vary in size and population, all are part of the state system with 33/35 actually administered by the Virginia Department of Health; the 2 locally administered districts function under

contract with VDH to provide public health services. All Districts receive both state and local funding through negotiated contracts with localities. This unified public health system has facilitated coordinated planning and response to all emergencies, from shootings to hurricanes, tornados and drought – the CDC contract funds a planner and epidemiologist in each health district as well as 4 regional teams to coordinate local planning and response efforts.

I will not spend a great deal of time discussing activities specifically funded by the CDC Public Health Preparedness funding. The EP&R Program of VDH has worked hard to assure coordination not only in planning and response activities but also in effective use of federal funds, no matter what the source of funding. This has included coordination of funding from HHS/ASPR, CDC and the Department of Homeland Security (DHS), specifically UASI and MMRS funding. The VDH EP&R program has been responsible for ALL federal funding for public health and healthcare preparedness and response, enabling us to avoid duplicate funding for the same or similar activities.

Key to the success of the Hospital Planning Program (HPP) in Virginia has been both the partnership between VDH and VHHA, as well as regional planning and response. VDH contracts with VHHA to manage and distribute most of the HHS/ASPR funding. Key program policies are determined and reviewed by the statewide Hospital Emergency Management Committee (HEMC) which includes representation from all regions, key healthcare provider groups and VDH, and meets every other month. Funds are distributed to each of six regions using a formula developed by the HEMC and approved by all hospitals which considers regional population, staffed hospital beds, ER visits, geographic area and perceived vulnerability. The regional planning group for each region includes representation from all hospitals in the region, Community Health Centers (CHCs), Community Services Boards (mental health) and other providers and determines the best use of HPP funds to meet the goals of the program in that region. This has allowed appropriate targeting of funds in each region while meeting the goals and benchmarks of the HPP in Virginia.

Each of the 6 hospital regions has a Regional Healthcare Coordinating Center (RHCC) and a regional hospital coordinator. The RHCC coordinates communications and tracking of resources, including hospital beds, as well as resource needs during an event. Each RHCC is in close communication with the VDH Emergency Coordination Center (ECC) and the state EOC during any event or exercise; the VDH ECC can then determine hospital needs and facilitate movement of resources statewide. Each RHCC is also the Level 1 Trauma Center for the region except for the Far Southwest where the RHCC is in Bristol, TN and serves as the major referral hospital for the region.

Funding from the Hospital Preparedness Program (HPP) has been used for a broad range of activities to enhance the ability of hospitals and the entire health system to respond to all emergencies. Use of these funds has included:

1. **Funding for limited administrative support within VDH and VHHA**
2. **Support of a regional hospital coordinator position for each of the 6 hospital planning regions**
3. **Purchase of redundant communications systems for all hospitals**, including satellite phones and radio systems
4. **Development of a statewide web based bed tracking system** that can be rapidly activated and accessed by any hospital in the state as well as by VHHA and VDH and is HAVBed compliant. VDH can therefore track bed availability statewide on a real time basis. The bed tracking system is also being expanded to track other key resources. Patient tracking and inventory control systems are also in development.
5. **Purchase of supplies and equipment, often done on a regional or statewide basis**. For example, 4 regions have purchased STIPs, portable facilities for Stabilization and Treatment in Place, and the state has one field hospital. Each STIP includes beds, supplies and equipment in addition to a tent to support either a triage facility for a hospital or a stand alone treatment site. STIPs can be shared among hospitals and regions; during Virginia Tech STIPs were rapidly available from 2 regions though none were needed. Other supplies and equipment have been purchased by individual hospitals.
6. **The state has purchased over 300 (308) ventilators** with ASPR and pandemic influenza funding that have been distributed regionally. After careful research on cost and functionality, one kind of ventilator was purchased for all regions with some placed in hospitals to allow staff to gain expertise using them.
7. **Antiviral and antibiotic medication** has been purchased for hospital staff and family use.
8. **Development of a Volunteer Management System** meeting the requirements of the Emergency System for Advanced Registration of Volunteer Health Professional (ESAR-VHP) Program, developed in collaboration with the 26 local Medical Reserve Corps (MRCs) in Virginia.

The importance of close collaboration and regional planning efforts for public health and healthcare, including hospitals, long terms care facilities, all healthcare and mental health providers, has been heightened in the wake of Hurricane Katrina. VDH is working with hospitals and long term care facilities to identify facility infrastructure vulnerabilities that may impact their ability to sustain operations during and after a significant incident. These mitigating actions may include protecting and improving the facility's emergency power generation, providing access to potable water including installing an on-campus water system where feasible, and otherwise "hardening" the facility. Hospitals have access to HPP funds for this purpose. Long term care facilities are eligible for FEMA pre-disaster mitigation grants. It is essential that, during the response and recovery phase, our healthcare facilities (hospital, long-term care and outpatient centers) are recognized by local, state and federal emergency managers as part of the critical infrastructure vital to public safety. Any barrier between the public and private sector and any obstacle to the allocation of public resource support for private sector elements of key public safety infrastructure (including most hospitals and long-term care facilities) must be resolved.

Trauma and Burn Care Systems in Virginia

The trauma system in Virginia was established in 1980 using modified American College of Surgeons criteria for Levels 1, 2 and 3 centers. The VDH Office of Emergency Medical Services (OEMS) has been responsible for evaluating, certifying and monitoring quality issues for trauma centers since their inception. At present there are five Level 1, three Level 2 and five Level 3 trauma centers in Virginia, with one additional hospital soon to be a Level 2 center. There are three burn centers in Virginia, with a total of 37 burn beds. Each of these burn centers is also a Level 1 trauma center.

In 2004, the Joint Legislative Audit and Review Commission (JLARC) of the Virginia General Assembly did a study entitled "Use and Financing of Trauma Centers in Virginia". Barriers to access to trauma care identified in this study included:

1. **Inadequate staffing**, with fewer physicians willing to participate in trauma centers because of financial, malpractice and quality of life considerations
2. **Declining reimbursements**. Trauma patients are disproportionately uninsured or covered by Medicaid and Medicare.
3. **High incremental costs** for serving as a trauma center, including increased staffing requirements.
4. **Overall it was estimated that in 2003, there were $44 million in unreimbursed trauma care costs in the Commonwealth**

This study had the following recommendations for financial support for trauma centers:

1. **Renegotiate contracts** with private insurers for improved reimbursement for trauma care: **Not likely to occur**
2. **Increase Medicaid reimbursement** to cover "readiness" costs: **Also not likely with tight state budgets**
3. **Create a fund to assist trauma centers with the uncompensated care burden**

As a result of the third recommendation, a trauma fund was created with:

1. $1,884,877 per year in general funds for FY 07-08. This was cut from the state budget for FY 08-10.
2. $40 additional fee for reinstatement of a driver's license after revocation or suspension
3. $50 from each person convicted of 2 or more DUI violations
4. **In 2006, $2.9 million was distributed to the 13 trauma centers in Virginia from the trauma fund; in calendar year 2007, $10.4 million was distributed.**

Clearly the trauma fund reimburses trauma centers for only a fraction of their unreimbursed costs for trauma care, though it is a step in the right direction. Any cuts in the Medicaid program would have a significant negative impact on those institutions providing trauma care, not only because of decreased reimbursement for trauma care but

also because these institutions are often those providing hospital care to a disproportionately high percentage of the Medicaid population. I know that you have heard Dr. Sheldon Retchin, a close colleague, present on the impact of Medicaid cuts in general for the VCU Health System in Richmond and for public hospitals nationwide.

Virginia Tech Shootings and Lessons Learned

With all our planning for terrorism and emergency events, no one anticipated the events of April 16, 2007 when 32 people were killed and 26 seriously injured at Virginia Tech in Blacksburg, Virginia. While not a true mass casualty incident, this was a major challenge for the hospitals in this very rural area. None of the injured could be transported by air to the closest Level 1 trauma center over 45 miles away because of snow and wind. Patients were transported to the nearest hospitals; of the three closest hospitals, two were Level 3 trauma centers and one was not a designated trauma center. The EMS response was rapid and coordinated, and none of the injured from Norris Hall transported to these hospitals died. Unfortunately, in additional to a significant casualty event, this was a fatality event. The Office of the Chief Medical Examiner, part of the Virginia Department of Health, performed 33 detailed autopsies for criminal investigation and scientifically identified all the dead for release to their families within 72 hours of the event.

Key lessons learned from Virginia Tech concerning mass trauma care included:

1. **Coordination of all parts of the public health and healthcare system is essential**, including EMS, hospitals, local and state public health. This was accomplished with rapid activation of all RHCCs, the local public health district, and the VDH ECC, allowing tracking of beds and resources on a real time basis.
2. **Cross training is key, as well as stocking of key supplies and equipment**. Training of staff in non-trauma centers to provide trauma care is now an increased priority in Virginia.
3. **Any mass casualty event is likely to include a significant number of fatalities**. A mass fatality plan that includes crime scene investigation is essential.
4. **There is a need for a real time patient tracking system** that links EMS, hospitals, and the Chief Medical Examiner with a Family Assistance Center so family members can rapidly determine the location of their loved ones. This is under development now in Virginia.

Trauma Surge Planning in Virginia

We are well aware that the greatest terrorist threat is from explosive events and have therefore studied the best way to assure trauma care surge capacity in the Commonwealth. This need was certainly highlighted by the Virginia Tech shootings where transport to high level trauma centers was not possible. In a mass casualty situation, we cannot depend on designated trauma centers to care for all the victims – all hospitals must be prepared to handle at least the initial care of trauma victims. This is

especially true of burn care, with relatively few burn units and beds designated in the Commonwealth.

Consequently, trauma surge planning now includes the following in Virginia:

1. **Placement of key supplies and medications for burn and trauma care in all hospital facilities.** For burn care, this includes availability of silver sulfadiazine (Silvadine) cream. For trauma care, additional supplies of antibiotics, narcotics (morphine), Silvadine and tetanus toxoid are essential. These are in addition to supplies of dressings and intravenous fluids.
2. **Training of physicians and staff in all hospitals to provide basic trauma and burn care;** this training had already begun prior to Virginia Tech.
3. **Training of EMS and hospital staff on appropriate triage during a mass casualty event.** With very large numbers of blast victims, some will not survive who might otherwise survive as a single trauma case. There must be a focus on those most likely to survive, which is still a difficult concept for healthcare providers in this country who work outside the military. In a significant resource limited situation (including limitation in healthcare providers) sole dependence on trauma centers is not appropriate. Once people are stabilized, there can be planning for transfer to more appropriate care sites, such as burn centers.
4. **Mass fatality planning must be a component of mass casualty planning.** With an explosive or other trauma event, some people are likely to die, as we have learned with both 9-11 and Virginia Tech.

Recent tornados

During the afternoon of Monday, April 28, 2008 Virginia experienced a number of tornados in the South-Eastern Region of the state. In spite of a great deal of destruction, there were no storm related deaths and only 3 serious injuries. Nonetheless, one small hospital in the Eastern Region treated 70 patients in a brief period of time. Communications among hospitals in the affected areas worked well, as well as communications between the Eastern Region RHCC and the Virginia Department of Health. The local health department was very involved in the response, including providing tetanus vaccine, doing home assessments, assisting with shelter activities, assuring safe food and water; both local and state health departments continue to distribute public health messages, including injury prevention and safe generator use. Three Medical Reserve Corps in the Eastern Region were activated to assist with home assessments and shelter support. Once again, these events impacted small suburban and rural areas of the state, reinforcing the need for statewide health system and public health emergency preparedness. The After Action Reports from this event will once again be used to identify strengths and challenges in the response, and then to modify plans accordingly.

Summary

1. Hospital and health system emergency preparedness can be achieved only through close collaboration and regional planning efforts for public health and healthcare (hospitals, long terms care facilities, all healthcare and mental health providers). Individual facility preparedness is not enough – there must be a system prepared to respond, especially for mass casualty and fatality events. Preparedness is tested through response to exercises and actual events.

2. A coordinated trauma system is important, but there must be a well thought out trauma and healthcare surge plan to effectively respond to large scale events; trauma care provided only through designated trauma centers will not be adequate or appropriate for a mass casualty event.

3. There remains a need for continued federal funding, both for public health and healthcare preparedness efforts, as well as for Medicaid support for healthcare facilities and providers. Much has been accomplished with CDC public health and HHS/ASPR health system preparedness funding but more remains to be done. Every event and exercise is an opportunity to enhance emergency plans through critical assessments and use of performance measures.

Thank you again for the opportunity to share Virginia's plans, challenges and accomplishments for public health and healthcare emergency preparedness and response with you today.

Chairman WAXMAN. Thank you very much. We're going to proceed with questions. Ten minutes will be controlled by the majority; 10 minutes controlled by the minority; and then we'll go right to the 5-minute rule.

But before I even begin questions, let me just get for the record something that I'm not sure I fully understand. Dr. Kaplowitz, what is a Level 1 trauma center? What is a Level 2 trauma center? What is an emergency room? How do these all fit in as you plan for emergency preparedness?

Dr. KAPLOWITZ. Well, actually, many people on the panel are better able to discuss the differences of Level 1, 2 and 3. Level 1 trauma centers require expertise to be present within the fatality all the time, to be able to handle any level of trauma. Level 2 and Level 3, some of that expertise can be outside the facility but available very quickly. So, again, Level 1 trauma centers have tremendous costs just to maintain that ability to provide trauma care. And that's a big part of what costs a great deal to maintain trauma centers. It's not only the care per se, but the infrastructure as well as a quality improvement plan, which we have a very good one in Virginia.

Emergency rooms are places where people can show up for emergency care in any facility, whether they're a designated trauma center or not. I will say that there are fewer and fewer designated trauma centers in the Commonwealth because of the cost to maintain a trauma center. It's been very, very difficult and becoming more and more expensive, and that's been very problematic.

Chairman WAXMAN. Thank you very much.

As I indicated in my opening statement, we asked the staff to do a survey of emergency care capacity in seven U.S. cities. At the time of the survey, none of the 34 Level 1 trauma centers that participated had enough treatment spaces in their emergency rooms to handle the victims of a terrorist attack like the one that happened in Madrid in 2004. In fact, more than half of the ERs were already operating above capacity. That means, on an average day, patients were already being treated in hallways, waiting rooms and administrative offices.

Dr. Meredith, should the findings in this survey be of concerns to Americans?

Dr. MEREDITH. Yes, sir. I think the capacity available today in our safety net hospitals is a problem, it is a threat. If you think about a bottle-neck theory, the patients are building up in the emergency departments, not because there's so many patients coming to them who shouldn't be there but because there's no place for them to go. The ability for our hospitals to absorb them just in terms of numbers of beds and numbers of doctors that take care of patients is lacking. And that's what's causing this emergency department overflow overloading and buildup. And the other pieces, one of the strategies is to move patients around, but as several of the other people on our panel have said, most of the kinds of patients that are occupying intensive care unit beds, ventilator beds, burn unit beds are not going to be very easily moved. They will be very difficult to move. And to move them from the Level 1 trauma centers and the burn units to other facilities is probably not the best way to manage them. So it's a problem.

Chairman WAXMAN. It's been over 6 years since we suffered the attacks on 9/11. Are our emergency rooms prepared to handle the surge of victims that could result from a terrorist attack?

Dr. MEREDITH. If you just—no, sir. I will just tell you from going to trauma center to trauma center, and I've been in a lot of them, there is very little surge capacity available in the trauma centers in the safety net hospitals in our country today.

Chairman WAXMAN. One of the striking findings of the survey is how overcrowded emergency rooms are on a normal day. This day, when our staff called the trauma centers and emergency rooms in the major cities, was just an ordinary day, and they were already over capacity. They had to treat patients in hallways and waiting rooms. I would like to ask, is overcrowding in emergency rooms jeopardizing the health of patients and the ability of hospitals to provide the best care possible?

Dr. Lewis.

Dr. LEWIS. First of all, the day that survey was conducted was a typical day, at least in Los Angeles. During that week in the prior 4 days we had been on diversion—I'm sorry, in the prior week, we had been on diversion for more than the equivalent of 4 days. So that was a typical situation. It absolutely negatively impacts the availability of the emergency department resources and the ability of patients to receive care for emergent medical conditions. There are delays in treating patients with chest pains, patients with potentially important infections and with a wide variety of illnesses and injuries.

Chairman WAXMAN. Well, the ability to respond to a bombing, such as occurred in Madrid, is called surge capacity. Surge capacity depends on more than just the emergency room. A hospital needs enough resources in places like the intensive care unit and hospital beds. But in the survey by committee staff, the problems extended beyond the emergency room. One major problem is something called boarding. Could you tell us, Dr. Lewis, what is boarding, and what impact does this have on emergency room abilities to deal with a surge?

Dr. LEWIS. Mr. Chairman the term boarding refers to the holding of a patient.

Chairman WAXMAN. Is your mic on?

Dr. LEWIS. Yes, it is. The term boarding refers to the use of emergency department treatment spaces for the holding of patients who are ill enough to require admission to the hospital, whose emergency care has been completed, they have been stabilized, and who the decision has been made to admit them into the hospital but there is no room in the hospital to treat that patient. Boarding has a number of important effects. The two most important effects are a reduction in the quality of care for that individual patient, because they are not receiving the ICU care in a comfortable and streamlined environment. But more importantly from my point of view and the purpose of this hearing is it reduces the total effective capacity of that emergency department. On a typical day in my emergency department, for example, one-quarter or as much as a third of the treatment spaces and the most intensive treatment spaces may be taken up by a boarder once we get to the afternoon

hours, and that reduces the effective size of my emergency department by that percentage.

Chairman WAXMAN. Well, what happened in Madrid was a terrorist bombing, just a bombing, and not a—when I say "just a bombing," not weapons of mass destruction or anything catastrophic other than what a terrorist attack using bombs can produce; 89 patients needed to be hospitalized, and 20 needed critical care. But not one of the hospitals surveyed had that many inpatient beds or critical care beds. In fact, the average hospital surveyed only had five intensive care unit beds, just a fraction of the 29 critical care beds needed in Madrid. Six hospitals had no ICU beds at all. Dr. Lewis and Dr. Conway-Welsh, are you concerned about these findings?

Dr. LEWIS. Obviously I'm concerned about the findings. One of the comments that's made in response to data like that is this idea that many of those patients could be rapidly moved out of the hospital in the event of an unexpected and catastrophic event. But, in fact, the information on intensive care unit availability is particularly problematic because those are patients that are too ill even to be in the normal treatment area of the hospital. So, as was mentioned by some of my colleagues, those patients are virtually impossible to move out. And so those spaces if they are used are truly encumbered and will not be available even in the setting of a mass casualty incident.

Dr. Welsh.

Dr. CONWAY-WELSH. There is another issue to that as well, and that is automobile gridlock. Many of our emergency rooms have not been designed to handle a large influx of private vehicles, which is what would happen. And I know, at Vanderbilt, if we got 50 cars lined up for our ER, that's it. I mean, they're not going anywhere. So I think that the gridlock issue as a concern for our emergency rooms is also very real.

I think Dr. Lewis made an important point when he said that the ER overcrowding, if you will, is actually a hospital problem. And I believe that is absolutely correct. And we're trying to fix something piecemeal when there's much larger problems, of which you are well aware, that really need to be addressed in a coordinated fashion by DHS and DHHS.

Chairman WAXMAN. Could you expand on that?

Dr. CONWAY-WELSH. Well, the role of coordination and guidance among those two offices is, frankly, very murky. And there is—if we recall the problems that happened with Katrina, it was sort of a right hand not knowing what the left hand was doing. There was, frankly, nobody to step in as a parent and say, you will play well in the sand box, you will get this done. And there was a lot of uproar between it's a State issue or a Federal issue or a city issue. That simply has to be stopped.

Chairman WAXMAN. It's been suggested that all of these things are supposed to be handled at the local level. The State ought to be able to coordinate emergency services. The hospitals ought to be prepared for whatever needs they might have. Some people have said that it won't really matter whether a hospital ER is operating way above capacity or even under diversion. If a bombing occurs and there are hundreds of casualties need immediate care, then the

hospital will simply clear out all patients who don't have life-threatening conditions. And if a local ER somehow can't create enough capacity, then care will be available in neighboring hospitals, in nearby communities or from emergency response teams deployed by the Federal Government. I wonder, is this grounded in reality, or is this an exercise in denial about the lack of emergency care surge capacity at the cities at the highest risk of a terrorist attack? Whichever one of you wants to respond.

Dr. CONWAY-WELSH. I think Tennessee accepts the responsibility that we must care for our own citizens. Frequently there are, particularly with blast explosions that can occur across State lines. Something else that is a real problem is that, for instance, the National Guard, which would be called up, they wouldn't get there immediately, but they would be called up, rely on the hospitals for a large part of their plans for response.

Chairman WAXMAN. Before my time is expired, let me just ask one last question. We talked about whether we're prepared and what the consequences would be for Medicaid funding to the States. Medicaid, of course, is health care for the very poor. Whether people agree or not about this particular issue on the Medicaid regulations, it will reduce Federal Medicaid revenues to Level 1 trauma centers and other hospitals throughout the country. Now, when that loss of Federal funds, which probably will vary from hospital to hospital, and for some Level 1 trauma centers, will these losses be substantial, forcing reductions in services and degrading emergency response capacity?

Dr. Meredith.

Dr. MEREDITH. Without question, that is one of my greatest fears as a result of this, is that the trauma centers which serve as the nucleus for this preparedness piece and for the problems that occur every day, every car wreck, the No. 1 killer of Americans under the age of 44, will not be able to survive without—if they have this much drop loss to their bottom line, they won't be able to do the things it takes to be able to be ready on an every day basis, much less be able to participate in any sort of surge. And that is frightening to me as a trauma surgeon.

Chairman WAXMAN. Thank you very much.

Mr. Shays.

Mr. SHAYS. Thank you very much, Mr. Chairman.

Dr. Lewis, are you familiar with research conducted at Johns Hopkins University and published in the Society for Academic Emergency Medicine that found there are key differences between daily surge capacity and catastrophic surge capacity? Specifically the research found that, quote, daily surge is predominantly an economic hospital-based issue with much of the problem related to in-patient capacity but with the consequences concentrated in the emergency department. By contrast, catastrophic surge has significantly more components.

Do you agree with the statement?

Dr. LEWIS. I agree with the statement, absolutely. The point that was being made——

Mr. SHAYS. Translate. Give me some meaning to this. Tell me what it means.

Dr. LEWIS. I think the distinction that's being made has to do with the ability of the hospital to respond to every day fluctuations in the need for care. For example, when there's a multi-car vehicle incident on the 405, and many of the hospitals in Los Angeles County have difficulty responding to those things but are able to respond by bringing in overtime staff, bringing in staff that aren't usually covered by the budget but for this one time can be brought in to open up beds that although physically available are not covered by nursing staff, those kinds of thing. However, doing that on a day-to-day basis over a fiscal year drives the hospital into the red. And so there are economic constraints on our ability to deal with so-called daily surge. In the setting of a mass casualty incident or a disaster surge, obviously there are some extraordinary things that would be done. I think the critical question is the extent with which those critical things could be done and how effective they would be given the number of acutely ill patients who in fact could not be moved out of the hospital.

Mr. SHAYS. Thank you.

Dr. Meredith, did you want to comment on it? You just seemed to light up a bit.

Dr. MEREDITH. Well, I think there is a lot—that's exactly right, and there's a lot of truth to that. You're much more able to lift a 300-pound weight if it's on your foot than you can if it's just sitting in the room. So we are able to be able to surge differently for an emergency and for a short period of time than you can do for a long period of time. There's also a disproportionate availability of bed capacity in our hospitals between the big urban and the Level 1 trauma hospitals and the smaller rural hospitals so that if you just look at the overall bed capacity over the country, it's mismatched between where these would occur, where the capacity is and so forth.

Mr. SHAYS. Mr. Chairman, I would request unanimous consent that the following articles published in the Society for Academic Emergency Medicine be entered into the record. There are 1, 2, 3, 4 of them. And I have them listed here if I could.

Chairman WAXMAN. Without objection, they will be entered in the record.

[The information referred to follows:]

The Measurement of Daily Surge and Its Relevance to Disaster Preparedness

Melissa L. McCarthy, MS, ScD, Dominik Aronsky, MD, PhD, Gabor D. Kelen, MD

Abstract

This article reviews what is known about daily emergency department (ED) surge and ED surge capacity and illustrates its potential relevance during a catastrophic event. Daily ED surge is a sudden increase in the demand for ED services. There is no well-accepted, objective measure of daily ED surge. The authors propose that daily and catastrophic ED surge can be measured by the magnitude of the surge, as well as by the nature and severity of the illnesses and injuries that patients present with during the surge. The magnitude of an ED surge can be measured by the patient arrival rate per hour. The nature and severity of the surge can be measured by the type (e.g., trauma vs. infection vs. biohazard) and acuity (e.g., triage level) of the surge. Surge capacity is defined as the extent to which a system can respond to a rapid and sizeable increase in the demand for resources. ED surge capacity includes multiple dimensions, such as systems, space, staffing, and supplies. A multidimensional measure is needed that reflects both the core components and their relative contribution to ED surge capacity. Although many types of factors may influence ED surge capacity, relatively little formal research has been conducted in this area. A better understanding of daily ED surge capacity and influencing factors will improve our ability to simulate the potential impact that different types of catastrophic events may have on the surge capacity of hospital EDs nationwide.

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Keywords: emergency department, ED overcrowding, catastrophic surge, surge capacity, disaster preparedness

Disaster preparedness has never been more important to our country than during the past few years, as a result of experiences with 9/11 and Hurricanes Katrina and Rita. All sectors of the health care system are focused on improving our ability as a nation to respond to future catastrophic events. Although a disaster may involve many components of the health care system, this article focuses on the emergency department (ED) perspective. Hospital EDs play an important role in disaster preparedness because they are the link between out-of-hospital and hospital resources. Many hospital EDs face significant surges in demand on a daily basis because of their commitment to providing unplanned, emergent, and nonemergent health care services to all patients who present. A natural question that arises is, how much of what we know about daily ED surge can we extrapolate to catastrophic surge and disaster preparedness? The purpose of this article is to review what is known about daily ED surge and to illustrate the importance of gaining a better understanding of the daily phenomenon, so that it can be used as a foundation to more accurately predict how well hospital EDs will respond to a catastrophic surge in the demand for their services.

Hospital EDs across the country have faced considerable challenges for more than two decades in dealing with daily surge.[1–6] Daily ED surge causes ED crowding in facilities that do not have adequate physical and personnel resources to meet periods of peak demand. ED crowding is the result of a mismatch between surge and surge capacity and signifies that daily ED surge capacity is compromised. It is important to identify and eliminate bottlenecks in daily operations so that EDs run as efficiently as possible given the resources they

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have. ED crowding illustrates system breakdown and the potential impact that insufficient surge capacity can have on the provision of timely, appropriate care.

SURGE

It is important to distinguish between surge and surge capacity. ED surge is defined as a sudden increase in the demand for ED services. Surge itself has not been of much interest to ED researchers or physicians. However, ED crowding, the consequence of daily ED surge, has received considerable attention by emergency physicians, hospital administrators, policy makers, and the public. Researchers and administrators traditionally have used surrogate indicators to quantify ED crowding, such as ambulance diversion, left-without-being-seen rates, or the number of patients boarding in the ED.[5] These indicators, however, measure the consequences of crowding or insufficient capacity, rather than daily surge itself. More recently, several multidimensional measures of crowding have been developed, but they include elements of both surge and surge capacity.[7–9]

In terms of ED operations, we propose that daily and catastrophic surge be measured by a combination of the magnitude as well as the nature and severity of the surge. The magnitude of the surge can be measured by the rate of patient arrivals to the ED. The nature and severity of the surge can be characterized by type (i.e., infectious vs. trauma vs. biohazard vs. illness) and acuity of the illnesses and injuries with which patients present during the surge.

Figures 1 and 2 illustrate the magnitude of daily ED surge by showing the percentage of new patient arrivals by time of day and day of week using 1996, 2000, and 2004 data from the National Hospital Ambulatory Care Survey (NHAMCS), which is a representative sample of approximately 400 hospital EDs nationwide.[10] Figure 1 illustrates that there is some degree of predictability in daily ED surge. Before the surge, at 6:00 AM, there are only 1.5 patients arriving per hour on average. The daily surge initiates around 7:00 AM and peaks at 11:00 AM (5.8 patients per hour). It plateaus at 6:00 PM (6 patients per hour) and then begins to decrease rapidly. However, it does not reach presurge initiation levels until after midnight.

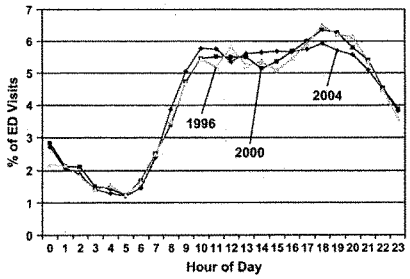

Figure 1. Percentage of ED visits by hour of day.

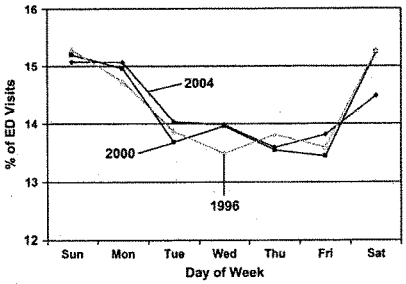

Figure 2. Percentage of ED visits by day of week.

There also is a trend by day of week, with a higher proportion of ED visits on Saturday, Sunday, and Monday compared with on other days of the week (Figure 2). By using time-series modeling techniques, Tandberg and Qualls forecast daily patient arrival for a six-month period on the basis of historical data from the previous year and were able to account for 42% of the variance in daily ED arrivals.[11] All EDs across the country should be examining their patterns of arrival by hour of day and day of week and using this information to optimize ED surge capacity by matching staffing and resources according to the seasonal trends in demand.

Figure 3 displays the percentage of new arrivals who are emergent (i.e., who should be seen in less than 15 minutes) by hour of arrival by using 2004 and 2000 NHAMCS data (the triage scale was different in 1996). Further examination of these data suggests that patient acuity varies moderately by hour of day but not by day of week (data not shown). EDs commonly experience a daily surge as a result of multiple trauma patients being brought to their facility, as may occur after a multivehicle collision. Although the magnitude of this type of surge is not remarkable, the nature and severity of the injured patients can challenge ED capacity. A surge that involves patients with a life-threatening contagious disease is very different from a surge that involves the so-called worried well or involves patients of low acuity. Although present ED-triage scales may capture the nature and severity of daily ED surge, they may not be adequate for characterizing the nature and severity of catastrophic surge.

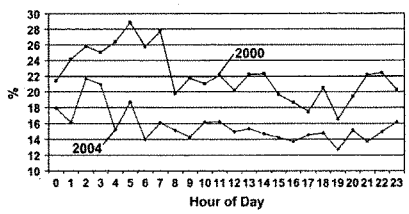

Figure 3. Percentage of emergent patients arriving by hour of day.

Surge Capacity

If we define daily and catastrophic ED surge in terms of the magnitude as well as the nature and severity of presenting illnesses and injuries, how do we define and measure ED surge capacity? The American College of Emergency Physicians (ACEP) defines surge capacity in general as a "measurable representation of a health care system's ability to manage a sudden or rapidly progressive influx of patients within the currently available resources at a given point in time."[12] This definition is a good first step but it fails to enumerate the essential components of surge capacity. An important advancement to disaster preparedness will be the development of a conceptual model of ED surge capacity that defines its core components and identifies potential factors that may influence it. Although daily ED surge and catastrophic surge may affect components of ED surge capacity to a lesser or greater extent, we argue that the definition and model of ED surge capacity should be one and the same for both types of surge.

The core dimensions of ED surge capacity include space (number of beds, physical size of ED, etc.), staffing, systems (admitting process, clinical information systems, ancillary services, etc.), and supplies.[13] A multidimensional measure is needed that reflects both the core components and their relative contribution to ED surge capacity. Furthermore, ED surge capacity also must be conceptualized within the health care system as a whole because of the influence that other system components will have on it.

Factors that Influence ED Surge Capacity

What little we know about factors that may influence ED surge capacity comes mainly from the ED-crowding literature. The best example of this is a hospital resource, inpatient bed capacity. A number of studies have found that hospital occupancy lengthens ED length of stay and increases the time that an ED spends on ambulance diversion.[14–17] Forster and colleagues found that when hospital occupancy increased by 10%, the median ED length of stay for admitted patients increased by 18 minutes (95% CI = 11 to 24 minutes).[15] Likewise, McConnell et al. reported that the average ED length of stay for patients admitted to the intensive care unit (ICU) decreased by 25 minutes after the hospital increased the number of ICU beds from 47 to 67. The increased ICU bed capacity did not significantly decrease the ED length of stay for patients admitted to wards or discharged patients.[14] Schull et al. also found that the number of patients boarding in the ED, a surrogate measure of hospital occupancy, significantly influenced the time that the ED spent on ambulance diversion.[16] When evaluating the adequacy of ED surge capacity for a catastrophic event, it is clear from these data that we also will have to consider inpatient bed capacity.

In addition to hospital characteristics, patient, provider, and community factors may also impact ED surge capacity. ED surge capacity may be influenced by patient characteristics, such as age, the presence of comorbidities, insurance status, and personal resources (e.g., social support). Provider characteristics that may influence ED surge capacity include clinical experience and skills, pace and other individual practice variations, stamina, psyche, communication skills, and teamwork abilities. Studies that address the effects of ED surge on provider behavior and patient outcomes in the ED are needed.

Finally, community characteristics, such as the availability of primary-care services, skilled nursing facilities, and home health providers could influence ED surge capacity. During a catastrophic surge, the marked delineation between out-of-hospital and hospital services may blur as all components of the health care system rally to treat those in need of medical care. Thus far, the only study to examine the impact of community characteristics on ED crowding did not find an association. The number of inpatients awaiting placement in a chronic-care facility in the community did not significantly influence the amount of time that the ED spent on ambulance diversion.[16] However, this area warrants further investigation.

CONCLUSIONS

There is much to be learned about ED surge and about the factors that influence ED surge capacity. Clinical information systems are essential to understanding patient flow and to improving operational efficiency. To accurately measure daily ED surge and to identify potential bottlenecks before they cause significant delays in patient flow, hospital EDs require real-time, simultaneous measurement of many factors that can predict daily ED surge and surge capacity requirements. Very few institutions, if any today, have the information-technology infrastructure to accomplish this task. With the appropriate data, time-series modeling techniques can be used to examine the influence of different factors on ED surge capacity on a minute by minute basis. An individual hospital's response to daily ED surge can be modeled, as well as multiple hospitals' response, by aggregating data across hospitals. Data from multiple sites will strengthen our estimates and allow us to identify site-specific variations that influence ED surge capacity.

With a better understanding of daily ED surge capacity and the factors that influence it, the knowledge of catastrophic events and how to manage them can be combined with advanced simulation techniques to predict the potential impact that different types of catastrophic events would have on the surge capacity of hospital EDs. To do this, however, the following are needed: 1) a common metric for measuring daily ED surge, 2) a conceptual model of ED surge capacity, and 3) better clinical information systems with real-time data on all important aspects of ED operations and clinical care. The best way to prepare for a large-scale disaster is to be better informed and prepared for the mini-disasters that many of us experience daily in the ED.

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Differentiating Large-scale Surge versus Daily Surge

J. Lee Jenkins, MD, MSc, Robert E. O'Connor, MD, MPH, David C. Cone, MD

Abstract

This breakout session at the *Academic Emergency Medicine* 2006 Consensus Conference examined how baseline overcrowding impedes the ability of emergency departments to respond to sudden, unexpected surges in demand for patient care. Differences between daily and catastrophic surge were discussed, and the need to invoke a hospital-wide response to surge was explored.

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Keywords: disasters, emergency departments

The *Academic Emergency Medicine* consensus conference breakout session entitled "Differentiating Large-scale Surge versus Daily Surge" was charged with defining resource requirements, responsible factors, and measurements of daily surge. In addition, the group was tasked with examining how surge capacity can be increased to manage a large-scale event and discussing the science of triage techniques during times of surge needs. The purpose of this proceedings report is to outline the discussions and findings of the group, limited as they were by time constraints. It should be noted that, as Kelen and McCarthy state elsewhere in this issue,[1] neither this breakout group nor the general conference came to consensus on the actual nature of the relationship between large-scale surge and daily surge.

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Breakout session participants: Richard Aghababian, John Allegra, Todd L. Allen, James Amsterdam, Howard Backer, John Becher, James Brown, Griffin Davis, Kenneth Fine, Carey Chisholm, Una Geary, Kendall K. Hall, Jonathan Handler, Fred Harchelroad, J. Lee Jenkins, Spencer Jones, Hyung-Goo Kang, Tom D. Kirsch, Kurt Kuykendall, Amanda Loveless, John McManus, Robert Muelleman, Robert Norton, Robert E. O'Connor, David Orban, May Otow, Kenneth Robinson, Incheol Park, Jedd Roe, Art Sanders, Terri Schmidt, Jeff Schunk, Richard Sinert, Corey Slovis, Thomas Terndrup, Debbie Travers, Matthew Walsh, John Weigand, David C. Cone, and Lynne Yancey.

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DIURNAL VARIATIONS IN PATIENT FLOW AND UNEXPECTED DAILY SURGE

Emergency department (ED) overcrowding is a nationwide problem affecting the preparedness and safety of our health care system. Its causes are myriad and its consequences far-reaching. Overcrowding can reduce health care quality by increasing the potential for medical errors, prolonging pain and suffering, and reducing patient satisfaction with services.[2] The effects of ED overcrowding in reducing surge capacity are intuitive but have not been quantified.

Problems with reduced surge capacity due to overcrowding are demonstrated daily in many EDs when the expected diurnal variation in patient arrivals outstrips the supply of ED beds and the ability of physicians and nurses to care for the patient load. It seems reasonable to postulate that the ability of an ED to absorb a sudden, unexpected increase in demand for services is less when the ED is already overcrowded. Surge capacity planning involves ensuring the ability to rapidly mobilize resources in reaction to such a sudden, unexpected increase in demand, regardless of baseline conditions in the ED. Because the nation's EDs are in a state of crisis due to overcrowding,[3] the unfortunate reality is that strategies to accommodate surge can be tested and refined on a daily basis; a true disaster is not required.

Surge capacity may be defined as the ability of the health care system to expand care capabilities in response to a sudden, unexpected patient influx, whether this is a smaller "daily" event, such as the arrival of ten trauma

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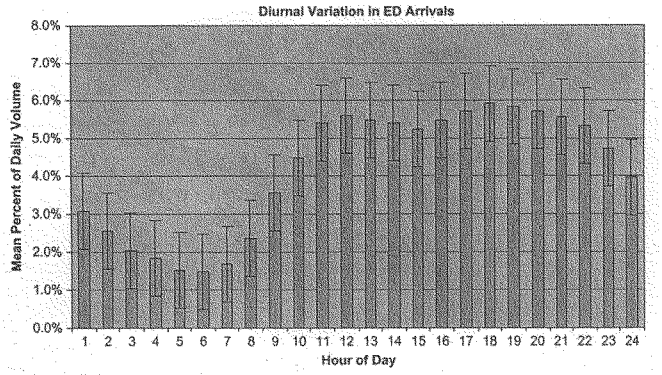

Figure 1. Percent of daily emergency department census arriving by hour of day, with 95% error bars. These data were drawn from 13 emergency departments.[9]

patients from a bus crash, or a larger-scale or catastrophic event, such as a major earthquake. (Elsewhere in this issue, Asplin et al. define daily surge as "the ability to respond to a sudden, unexpected surge in demand using only the daily operating resources of the hospital. If a disaster response plan is activated or additional resources are required beyond those that are normally available for operations, the surge in demand has exceeded the threshold of daily surge capacity."[4]) The predictable daily flow of patients is evident as a characteristic diurnal curve (Figure 1). The ability of the ED to react to an unexpected surge in demand for service thus varies based on time of day, with there likely being greater surge capacity in the early morning, when ED census and arrival rates are typically low, and lower capacity in the evening, when census and arrival rates are high.

Many factors other than the sheer volume of newly arrived patients contribute to ED crowding, such as length of stay, acuity, and need for inpatient services. These variables do not exist independent of one another, and simple statistics such as daily volume or patient arrivals per hour provide incomplete information. Patient-hours may be a more accurate measure of service demand because both volume and length of stay are accounted for. For example, patients whose emergency evaluation has been completed but who are awaiting inpatient beds continue to consume ED resources and reduce the ability of the ED to care for newly arrived patients. Surge may thus be determined by the volume of patients with emergent needs, with the complexity of cases involved playing a role in resource depletion.

The Institute of Medicine recently released a report that focused on three areas of emergency care: the prehospital care system, emergency departments, and pediatric emergency care.[3,5,6] Capacity statistics that were cited indicate that an increasing demand for service, coupled with dwindling capacity, is stretching the system to the breaking point. For example, the number of ED visits increased by 27% from 1993 to 2003, from 90 million to 114 million, although the population increased by only 12%. During the same period, 425 EDs closed and the number of hospital beds decreased by 200,000. As a result, many EDs are overcrowded and cannot provide the timely care required by patients with serious illness or injuries. Many patients must wait hours for a physician and days for a hospital bed due to overcrowding, which, in turn, leads to ambulance diversion. Because of the capacity crisis, the emergency care system lacks surge capacity to address large disasters or disease outbreaks.

To meet the demands of surge and increase capacity, methods must be found to improve hospital efficiency and patient flow to the inpatient setting. To use the full capacity of hospitals in different catchment areas, there must be coordination and regionalization of the emergency care system with accountability for each component of the system. The Institute of Medicine study recommends that states and hospitals establish emergency health systems coordinated regionally to direct patients and help prevent overcrowded EDs. In addition, the study recommends that Congress allocate resources to reimburse hospitals for uncompensated emergency care and to fund the establishment of a network to provide regional care to address the issue of surge capacity. EDs that remain overcrowded on a daily basis are ill equipped to handle a large spike in patient volume due to large-scale surge and disasters or even a relatively small surge, as might occur after a "routine" multiple-casualty event.

CATASTROPHIC SURGE

A large-scale public health emergency has the potential to result in great numbers of human casualties; however, disasters are highly variable in the pattern of surge that is produced. While it is tempting to think of surge following disaster as a single spike in volume, some natural disasters such as floods and hurricanes may produce

sustained increases in demand for services where the surge is sustained over weeks, months, or years.[7] The dividing line between unexpected daily surge and large-scale catastrophic surge may not always be clear, and the two probably exist on a continuum and not as two separate entities. Recent events, such as Hurricanes Katrina and Rita and the potential threat of an avian influenza pandemic, may have resulted in a shift in efforts away from preparation for smaller surge events that are experienced on a daily basis in our nation and toward preparation for much less frequent large-scale disasters. It is worth noting that the patient care requirements may be disproportionate to the number of patients, based on the type of surge event. For example, detonation of a "dirty bomb" may result in an overwhelming surge in resource needs despite a relatively low number of patients if resources to manage radiologic contamination are limited, even if the number of actual patients is not large.

The activation of large-scale disaster response plans should result in drastic changes in patient flow, both in the ED and throughout the hospital. Such changes should include the discharge of stable inpatients and ED patients, canceling of elective operative procedures, and opening of alternative arenas of medical care. Recognizing the differences between the Monday-to-Friday daytime operations of most elective surgery and the 24/7/365 operations of the ED, there are recommendations to smooth out the surgical census by moving elective surgery to Saturdays, Sundays, and evenings, avoiding the otherwise inevitable Monday logjam of elective surgery census.[8]

While the causative factors leading to unexpected daily surge and large-scale disasters may differ, we propose that the response to both should be a gradation in how we change our everyday activities and not an all-or-nothing response. A multistep or graded response to surge likely presents the most effective and efficient method to address both unexpected daily surge and large-scale disasters, although definitions, metrics, and study of this are very limited. Each ED should identify surge measurements or metrics at which various solutions would take effect. These solutions should not be solely activated in the ED, but rather within the hospital as a whole. Many hospitals already use a "zone" or color-coding system to indicate how crowded the ED is, based on factors such as number of admitted patients boarding in the ED (and the subset of these patients bound for an intensive care unit), number of patients in the waiting room, waiting time to be seen by a clinician, and so on. Some of the potential solutions to crowding that may be invoked when a certain "zone" is reached include boarding admitted patients on other floors until their inpatient beds are ready, sending admitted patients to the floor earlier than usual, and calling in additional personnel, such as additional emergency physicians, trauma surgeons, nurses, and other consultants. These steps recognize that no ED exists in a vacuum and that the hospital must view patient safety in the ED as a primary responsibility, even during times of overcrowding and surge. While internal resources to the ED are shifted to accommodate surges, changes may need to extend beyond the ED to the inpatient setting. Boarding low-acuity patients who are awaiting discharge or laboratory results in outpatient areas may help open inpatient space for admitted ED patients. These and other strategies require research to quantify their impact and effectiveness, both in the setting of ED crowding and in the context of surge. They also require acceptance at the level of senior hospital administration that the entire institution, not just the ED, is responsible for dealing with surge. Many of the breakout session participants noted that it is a general expectation that the majority of a surge will be absorbed and dealt with by the ED, while a small amount of "leakage" may be allowed to trickle to the operating suite, recovery areas, intensive care units, and patient floors. This perception needs to change.

RESEARCH QUESTIONS

During our discussions, the breakout group encountered a number of unanswered questions and areas needing further research. For example, it was noted that further information is needed regarding how long it takes to return the ED to baseline operations after a surge is handled. Does a "larger" response to a surge help get the ED back to baseline faster than a "smaller" response? How can we study the relative effects of various responses, and how can we determine the "best" responses (most effective, least expensive, and so on)? Most of the work in this area appears to be service-line and process work; what is the role of outcomes research? Can we shift the emphasis of this sort of research to outcomes and, if so, how?

Regarding the implementation of responses to surge, how does (or should) the clinician know that he or she is now facing a surge and should "pull the trigger" to implement ED and hospital-wide responses? For noncatastrophic events, is it possible to predict the trajectory of the ED census or make probabilistic inferences about resource demands in the near term? What are the predictor variables in an "early-warning system" for the different types of surges?

CONCLUSIONS

ED overcrowding is a daily occurrence across the nation, and it severely impedes the ability of the emergency health care system to respond to a sudden surge in the demand for services. This surge in demand may be due to large numbers of patients presenting over a brief period or due to sustained increases in volume. In addition, relatively small numbers of patients with extensive demands for complex, resource-intensive specialty services may overwhelm the system. Emergency care systems must be able to react to these three scenarios by responding to the known, predictable, daily variations in demand for services, sudden spikes in demand, or an increase in volume sustained over time, each of which requires very different strategies.

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Daily Patient Flow Is Not Surge: "Management Is Prediction"

This issue of *Academic Emergency Medicine* (*AEM*) compiles both the proceedings of the *AEM*-sponsored annual consensus conference, the theme of which this year was the "Science of Surge," and various related science and opinion articles on surge and related topics. One of the primary missions of the conference was to explore the concepts of daily surge and disaster surge and to determine their relationship, if any. The consensus-conference planners coined the term *daily surge* as a starting point to contrast with *catastrophic surge*, a term indicating what a system must do to manage large numbers of casualties, such as occurred in the aftermath of Hurricanes Katrina and Rita in 2005 and of the Southeast Asia tsunami of 2004. A reading of the proceedings papers in this issue demonstrates inconsistency in the use of the term *daily surge*, thereby generating a degree of confusion, because some authors equate it with emergency department (ED) crowding, whereas others reserve the term for sudden, unexpected increases in demand for services. This lack of standardized terminology is illustrative of the fact that the science of surge is conceptually challenging and in its infancy.

We agree with the various proceedings authors' insistence on implementing multidisciplinary groups for medical and health management after a catastrophic event[1]; catastrophic surge is not our focus here. However, the use of the term *daily surge* is problematic. We assert that the term is in fact a misnomer for the admittedly dynamic, yet relatively predictable ebb and flow of the daily volume and acuity of patients presenting to our EDs consequent to the illnesses, injuries, and social circumstances afflicting them and their communities. We are persuaded that although most EDs already staff on the basis of some notion of demand for service, this effort is mostly unscientific and hence incomplete and likely is not effective in delivering consistent quality of care across a spectrum of patient demand and arrival load.

Emergency-department crowding, called *daily surge* by some proceedings authors, may be mostly a failure of a national public health care policy that funnels patients to EDs consequent to lack of access to care; it surely is not subsequent to an unpredictable event such as a catastrophic disaster. We assert that the reason the question of daily surge even exists is the lack of a basic public-health infrastructure with appropriate access to care. Kelen and McCarthy acknowledge, and we agree with, the evident mismatch of demand for care with resources available for care, though they assert that "given that the problem is primarily economic, incentives to address ED crowding are mixed at best."[2] Although economic scarcity surely motivates the behavior of hospital managers and of consulting and admitting physicians, emergency physicians and ED managers are not without resources, and we further suggest that until emergency physicians and ED managers embrace the technologies of modern service management,[3] we cannot know whether crowding is the consequence of the apparently inequitable judgments of the aforementioned hospital managers and consulting physicians or is a challenge to management that leaders can anticipate and for which cogent responses may be implemented. Our uncertainty is amplified when we note, for example, the reported successes of Hoffenberg et al.[4] and Spaite et al.,[5] who, by adopting aspects of modern service management in their respective facilities, demonstrated decreased throughput intervals for their patients. As Spaite et al.[5] note, decreased throughput interval has the net effect of adding rooms to the department, actually increasing capacity to see new patients. We believe that the successes of Hoffenberg et al.[4] and Spaite et al.[5] reinforce our assertion that the lack of implementation of demand-management systems in EDs (as already exist in engineering and even in emergency medical services systems) is a major part of the problem, although we also believe that it is not just the lack of a management system; we also need a basic infrastructure upon which to build. No matter how good the management system is, underlying resources and standard operating procedures are needed upon which to build the systems that are needed to manage surge.

Although we do not intend to be comprehensive, we nonetheless note the hopeful trend in recent years of increasing publication of reports (descriptive, analytic, and prescriptive), all addressing clinical-operations issues in our EDs.[6–13] Welch et al. recently published metrics useful for comparing EDs, in part by measuring the capacity of the ED for patient care.[14] Other static measures, as recommended by authorities as disparate as the Advisory Board Company and the Urgent Matters Project, are becoming the cornerstone of processes that predict demand and, through operations improvement, maximize capacity. Even so, these static measures may have limitations when addressing the hyperdynamic patient flow of the ED.[15]

Considering surge as a challenge to quality, and adopting the Donebedian structure–process–outcome model as a framework for evaluating the effectiveness of responses to surge, are worthy of consideration and scientific study. The output of the consensus conference then could be viewed as contributing to the development of

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concepts and measures for use in evaluating the effects of surge on quality.

Regarding the conference itself, as both leaders and participants, we accept responsibility for, yet regret, the fact that Welch et al.,[14] whose summit convened more than three months before the "Science of Surge" consensus conference, is cited by no other authors in this issue.

That work, published in the October issue of this journal,[14] apparently was unknown to most or all conference participants at the time. Although emergency medicine historically has drawn heavily on the work of investigators outside our own field, in this instance it seems unfortunate that for the discussions regarding daily surge and related metrics, we did not use the information from a colleague in our own field as a starting point instead of reinventing the wheel. Perhaps we just have too many consensus projects out there: we are not sharing information and are not reaching consensus on much of anything.

The ED serves patients and stands in readiness to serve individuals and entire communities in time of need. Our EDs also serve as learning laboratories, not merely for medical students on ED rotations and for emergency-medicine residents but also for all trainees learning medicine and surgery. Professional management, using the tools of modern service industries, may help us improve care and customer satisfaction while optimizing patient outcomes and is a necessary first step before we know whether our hospital-based emergency-care system is "at the breaking point"[16] because of policy failure, management failure, or both. In summary, the term *daily surge* is misleading and not reflective of the issues surrounding daily ebb and flow, smaller unexpected surges in demand for services, or catastrophic surge; rather, management is prediction.[17]

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The Science of Surge

Three years ago, a Web search that included PubMed yielded few research studies related to surge or surge capacity, whether specific to hospital emergency departments (EDs) or to catastrophic events. The information on the Internet yielded mostly PowerPoint slides of meeting presentations by notable individuals. At that time, the few published reports on disaster-related surge were mostly opinion or non–evidence-based assertions. A review of texts related to medical disaster response published at the time also yielded an astounding paucity of information on surge. At best, they noted that plans for surge should be developed.

By contrast, the science of ED crowding, a consequence of daily surge (also referred to as regular surge and routine surge), was already well developed. Many of the methods used borrowed heavily from operational and management science and a division thereof called service management.[1] These methods included concepts such as queuing theory[2–4] and discrete event simulation modeling,[5,6] and use of these techniques to analyze daily surge experienced by EDs has continued to mature. Interestingly, the actual operational definition of "crowding" has not yet attained uniform agreement, although tools to measure the phenomenon have been developed and tested.[7]

Recognizing the importance of developing the scientific underpinnings of disaster planning and response, the Agency for Healthcare Research and Quality, among a few other organizations, decided to support formal research inquiry into extraordinary surge[8,9] (also referred to as catastrophic surge, critical event surge, and disaster surge), the endeavors of which are just now reaching fruition and are being presented and published.[10–15] Many other reports remain conceptual, but such reports are increasingly based on best evidence when available.[16]

CONCEPT OF SURGE, SURGE CAPACITY, AND SURGE RESPONSE CAPABILITY

Before the *Academic Emergency Medicine* consensus conference entitled "The Science of Surge," held in San Francisco in May 2006, the concepts of surge and surge capacity were not applied to daily health care practice, but rather were the vernacular of disaster or emergency preparedness. In this realm, formal definitions of surge capacity have been offered,[17,18] but "surge" itself remains undefined. The term "**surge response capability**" as a function of these two concepts has not, to our knowledge, previously been introduced (Figure 1) but will be discussed later in this report. The lack of accepted definitions hinders research, because metrics of measurement cannot be developed in absence of conceptual clarity.

During a recent Agency for Healthcare Research and Quality–sponsored conference, surge was undefined but was acknowledged to have components of volume and time.[18] Event type and scale broadly determine surge. We offer the following conceptual definition of surge. Surge is defined as a sizable increase in demand for resources compared with a baseline demand. Related to health care, surge implies a sizable increase in demand of medical or public health resources. In addition to influx (volume rate), surge is further composed of the following components: event (type, scale, and duration) and resource demand (consumption and degradation) (Figure 1). Contrary to current thinking, surge itself is largely independent of resource availability (surge capacity). However, as explained later, it is related to capacity insofar as both are functional elements defining surge response capability (Figure 1).

Surge capacity is the maximum potential delivery of required resources, either through augmentation or modification of resource management and allocation. Surge capacity contains the elements of system, space, staff, and supplies, as outlined by Barbisch and Koenig.[19] Surge capacity is not necessarily or entirely independent of surge, because the demand characteristics of the surge itself may consume and degrade resources. Again, the two parameters are linked in that they define surge response capability.

Finally, surge response capability is a concept we are forwarding here. We believe this concept has been confused with surge capacity. Rather, it is the ability of surge capacity (i.e., the resources that can be made available) to accommodate the surge (demand for resources). In essence, it is the measurable function of surge capacity related to surge (Figure 1). When surge capacity exceeds the demands of surge, the response capability is >1. Under these circumstances, the surge may not even be perceived. On the other hand, when surge capacity is insufficient to meet surge demand, surge response capability is inadequate. This may appear intuitive, and critics may argue that surge capacity alone subsumes this definition. However, resource availability and maximized management (capacity) are independent of the event that creates incremental demand (i.e., surge). The extent to which surge capacity can accommodate the surge is surge response capability. The science of surge can only be advanced if these concepts are appropriately defined such that metrics can be applied.

The definitions offered here are somewhat new and may prove controversial. It is likely that these concepts will be refined further over time by other investigators and experts. Although our concern in this report is with health care, the concepts should be equally

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$$\text{Surge Response Capability} = \text{Planning} * \frac{\text{Maximized Available Resources}}{\text{Resource Demand}}$$

$$= \text{Planning} * \frac{\text{Surge Capacity}}{\text{Surge}}$$

$$= \text{Planning} * \frac{\text{System}_{(\text{integrity})} * \text{Space}_{(\text{size} * \text{quality})} * \text{Staff}_{(\text{numbers} * \text{skill})} * \text{Supplies}_{(\text{volume} * \text{quality})}}{\text{Event}_{(\text{type} * \text{scale} * \text{duration})} * \text{Influx} * \text{Resource Demand}_{(\text{consumption} + \text{degradation})}}$$

Figure 1. Functional relationship of surge response capability to surge capacity and surge. Note that planning, which is actually a system component, is shown as a major stand-alone variable to emphasize its importance.

applicable to electricity grids, public transportation, theater offerings, and so on.

HEALTH SYSTEM DAILY SURGE AND EXTRAORDINARY SURGE

How do the concepts of daily surge and extraordinary surge relate? The two concepts are similar in that both contend with a sizable increase in medical or public health resource demand and challenge system capacity. However, extraordinary surge, a term reserved for catastrophic events, is larger scale, is more complex, and has incremental nonlinear multicomponent interactions with capacity compared with its simpler cousin, daily surge. In addition, there are considerable differences that may affect research approaches to studying the problem and finding solutions.

While it is hard to deny that ED crowding exists, not all believe that daily surge as a concept exists. The fact that the term "daily surge" was coined coincident with the *Academic Emergency Medicine* consensus conference, and is not previously found in the literature, supports this view. It is also argued that because crowding is not concerned with sizable abrupt, unanticipated, or sudden demand, there is no concept of surge. It is also argued that daily surge is predictable, and because it is routine and expected, it cannot be a surge. In contrast, others argue that the fact that an incremental demand in health care resources is predictable and occurs routinely does not render the phenomenon any less real. Data presented by McCarthy et al. elsewhere in this issue reveal sizable and abrupt (but not completely unanticipated) increments in hospital-based health care resource demand on a routine basis.[20] Further, crowding, the result of mismatch between demand (surge) and resource availability (capacity), can be considered a measure (not a favorable one) of surge response capability. Perhaps the best conceptual view is that of a broad continuum with daily surge and extraordinary surge at the two extremes. Asplin et al., in this issue, offer a reasonable differentiating approach.[21] Daily surge response capability invokes only routinely available capacity (resources). At the other end of the continuum, a disaster plan is activated, triggering augmentation or alternate management of resources on a much larger scale as a means to accommodate the surge. It is easily imagined that there are scenarios of degree between. Regardless, the basic tenets of the interrelationships between surge response capability, surge capacity, and surge appear to hold for both daily and extraordinary situations.

Although conceptually related, daily surge issues are distinct in many ways from extraordinary surge. Daily surge and the consequences of crowding refer almost exclusively to ED experiences. It is fundamentally based on economic hospital-based decisions, complicated by misunderstood data indicating that many patients seeking ED treatment do not really have a true emergency, and thus crowding is viewed as a problem of unnecessary visits.[22] A large component of the capacity-to-demand mismatch is related to inpatient census.[23–25] In contradistinction to catastrophic events, the components of daily surge and surge capacity, as well as their relative contribution to crowding, have been well defined for the better part of two decades. Thus, solutions to effectively increase daily response capability and components exerting the greatest effects are evident.[26]

Given that the problem is primarily economic, incentives to address ED crowding are mixed at best. On the one hand, there are ample data indicating that admissions to hospitals from sources other than the ED are more revenue generating.[27–30] Elective admissions and transfers are even more financially advantageous. Thus, at the level of the individual admitting attending physician or admitting service level, admissions from the ED are among the lowest of priorities in many hospitals.

Further, timeliness of consultations to the ED also appears to be highly associated with economic prospects.[31] Obtaining consultations from on-call specialists in nonacademic centers has recently reached crisis proportions, as specialists are opting out of emergency coverage.[32] The only incentives countering these trends are hospital image and avoidance of costly malpractice suits, as well as Emergency Medical Treatment and Active Labor Act investigations and citations. Given the extraordinarily thin financial margins under which many hospitals operate, hospital administrators and physician leaders may have very little maneuverability to truly address the issue of ED crowding.

Finally, emergency medicine itself is also responsible for buying into the economic model of impeded capacity. Because emergency medicine group practice is often for-profit or predicated on concerns of financial margin, management keeps attending staffing at a level in which physicians should never be idle. In this model, staffing for maximum known demand is not economically sound, because the physician or provider would be idle for considerable periods during lower demand times.

By contrast, response to extraordinary surge and attendant capacity is generally not economically based (beyond general concepts of continuity of operations, that is, business continuity). Rather, as with all aspects of disaster response, it is based on the higher humanity standard of equal access and the guiding principle of "greater good for the greatest number."

Finally, surge during catastrophic events is a broader concept than daily surge, and viewing the issue from the emergency medicine perspective alone is myopic. Daily surge is predominantly an economic hospital-based issue, with much of the problem related to inpatient capacity but with the consequences concentrated in the ED. By contrast, catastrophic surge has significantly more components. Revenue generation and meeting certain financial margins are limited drivers at best, and ED operations are just one facet. The broader public health system is frequently involved, as are community infrastructure, regional (even national) assets, and political institutions. In fact, in some scenarios, the ED may play only a modest role in a catastrophic event and in some may not play any role that is fundamentally different than for daily surge.

COMPONENTS OF SURGE CAPACITY

As noted, the components of daily surge and their interrelationships are well known and have been well studied for the better part of two decades. McCarthy et al. argue that daily surge is somewhat predictable on an institutional and regional emergency medical services (EMS) basis, for both seasonal, day of the week, and intraday effects.[20]

The Advisory Board Company conducted groundbreaking work during the late 1990s, delineating the various elements of ED crowding and the relative value of addressing the different components.[26] It was determined that there are 22 components related to ED bottlenecks and delays, each with its own subcomponents. They concluded that the greatest determinant of ED surge capacity was the "back-end" admission process. "Up-front" process improvements, while helpful, offered the least value in increasing capacity for a continuous or intermittent surge in patients.

During the 1990s, the concept of categorizing surge capacity into four broad components (system, space, staff, and supplies) did not exist. Table 1 categorizes the 22 impact components according to these four categories. These 22 components are a subset of the universe of components and represent the ones with the greatest effects. As noted earlier, it has been advanced that inpatient census, an issue of space and staff, is a major driver and perhaps has the greatest impact on ED crowding. Our own unpublished data contradict this notion. The Advisory Board Company itself did not characterize inpatient census as influential but noted that many of the processes involved in admissions (which falls under the rubric of "system") were the major impact components. It is also interesting to note that, generally speaking, apart from specific dedicated staff for specific tasks, staff components were not major influencers and supplies were virtually never a capacity component in question during daily ED surge (Table 1).

Unlike daily surge capacity, extraordinary surge capacity is not as well understood. The fundamental elements of extraordinary surge capacity have been broadly classified,[19] but the components within the classifications have not been detailed in a universal model. Table 2 is an initial attempt at delineating influencing components of extraordinary surge capacity, and Figure 1 depicts surge response capability as a function of the elements of surge capacity (resource availability) and surge (resource demand). The relative contributions of the broad categories depicted in Table 2 and Figure 1 remain unexplored. Moreover, the dynamics between extraordinary surge components and capacity components are infinitely

Table 1
Components of Daily Surge Capacity

System
Pre-ED bed
Triage method (short vs. long)*
Registration method (pretreatment vs. bedside)*
Physician tasks
Documentation methods
Communications (physician vs. dedicated staff)
Diagnostic results notification (passive vs. active)
Ancillary ordering
Method (freeform vs. guidelines)
Treatment
Ordering (guidelines vs. freeform)
Space utilization
(routine use vs. swing rooms)
Radiology reads
(EP first read vs. radiologist)*
(EM preferential reads by radiologist vs. not)
Admission process
Bed allocation (Preemptive request vs. post hoc allocation)*
Nurse report technique
Bed status alert
Authority (EP vs. permission)
Informatics
Patient tracking (present vs. not)*
Inpatient bed status (instant vs. not)
Physician profiling (yes vs. no)
Other
Physician ancillary use profiling
Space
Laboratory (on site vs. distant)
Staff
Phlebotomists (dedicated phlebotomy vs. multitasking personnel)*
Radiologists (dedicated to ED vs. not)*
Inpatient MDs (hospitalists vs. individual service)
Supplies (no items)†

EP = emergency physician; EM = emergency medicine.
* Judged as having the highest level of importance.
†The Advisory Board Company[26] did not report any issues related to ED crowding or capacity.

Table 2
Components of Catastrophic Event Surge

System	Space	Staff	Supplies
Planning	Facilities	Numbers	Biologics
Community infrastructure	Medical care	Capability/skill set	Respirators
Government	Storage	Expertise	Personal protective equipment
Informal networks	Laboratory	Stamina	Standard supplies
Public health	Mortuary	Psych	Food and water
Incident command	Housing of staff		
All levels			
HEIC	Quality		
Regional cooperation	Size		
Multiagency	Capability		
Regional health system	Location		
Communications and information flow			
Supply chain distribution			
EMS/first responders			
Continuity of operations			
Cybersecurity			

HEIC = hospital epidemiology and infection control.

more complex and change according to event type and duration.

SCIENTIFIC UNDERPINNINGS OF SURGE

One goal of the "Science of Surge" consensus conference, the record of which is documented in this issue, was to determine whether the scientific methods applicable to daily surge could be shown to be applicable to extraordinary surge scenarios. However, no consensus was reached as to the relationship of one concept to the other, or whether they are related at all. The definitions offered in this report suggest that, in the least, daily surge and extraordinary surge may represent opposite ends of a continuum. Support for this concept is derived from the fact that methods of study are common to both phenomena.

Even before the work of the Advisory Board Company, the science of daily surge borrowed heavily from operations engineering and various modeling concepts such as queuing theory. Even chaos theory applications have been explored.[33,34] More recently, attention has been paid to patient safety issues related to daily surge and capacity constraints, but the methods of study for this line of inquiry are well developed. While there is much work that remains, such as the need for an accepted definition of crowding and universal metrics of measurement, overall, progress in the scientific underpinnings of the study of daily surge is quite mature compared with the study of extraordinary surge in catastrophic events.

Despite these fundamental differences, there are methods of inquiry applicable to both daily surge and catastrophic surge. Discrete event simulation modeling techniques have also been used to analyze surge issues in catastrophic events.[35–37] For example, Hirshberg et al. used data from 12 terrorist bombing incidents in Israel to determine that surgeons (not operating rooms), resuscitation rooms, and computed tomography scanner availability determined the admitting capacity of a hospital.[36]

Similarly, concepts developed to address scarce resource utilization in catastrophic events may be applicable to daily surge issues. Two recent lines of inquiry may assist with inpatient census issues. Hick and O'Laughlin recently published an ethical framework for the triage and allocation of intensive care unit beds and mechanical ventilation when these resources were insufficient due to a catastrophic event.[38] On a daily basis, intensive care unit resources are rationed routinely in many, and perhaps most, hospitals. In fact, the ethical framework for the current routine practice is not founded on public health principles. Those in great need and those likely to benefit may actually be denied the service, while the allocated resource continues to be used for those with low likelihood of beneficial outcome. Further, intensive care unit beds are often "reserved" for patients undergoing elective surgery, while patients who could benefit linger in the ED, clearly a less ideal environment for patients requiring intensive monitoring or care. "The most benefit, for the greatest number," the clarion call of disaster management, is not one that has yet been adopted in routine health care.

In a similar line of study, Kelen and the CEPAR Research Group have developed a framework for safe discharge of inpatients during disasters that may be applicable to daily surge as well.[14,15] Preliminary data indicate that, in fact, a sizable portion of inpatient beds can be freed using a technique of deciding early rapid discharge for patients with low risk of adverse events for a subsequent 72-hour period.[16]

SUMMARY

While it remains unclear to what extent daily surge and extraordinary surge are related, it is evident that their philosophical underpinnings are divergent. However, at least some tools appropriate for study are applicable to both, indicating conceptual similarities. The phenomena of daily surge and the components of daily surge capacity are well known and studied. The phenomenon of extraordinary surge, by comparison, is complex. The components of surge capacity for catastrophic events are only broadly defined, and many subcomponents remain undefined. Further, the relative impact of the various components under different event scenarios remains largely unknown.

The interactions of these components are not stable and are dependent on the event type and duration. Still, a new concept, surge response capability, can be expressed as a function of surge capacity and surge characteristics. The main challenge for developing the science of surge is to further delineate the components of surge capacity and surge and to develop measurable operational definitions that would be subject to testing and evaluation.

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Mr. SHAYS. Thank you very much.

Dr. Hoffman, I find it nonsensical that we talk about the capacity in emergency centers and so on, that we are strained, when particularly in California my sense is that a lot of this deals with the uncompensated care, not the undocumented worker because that doesn't describe them. It's individuals who are literally here illegally. Is there any sense of a disconnect when we say we are providing national security for our homeland when in fact we allow individuals to literally come into this country at will, then call them undocumented, as if somehow they don't represent a national security issue?

Mr. HOFFMAN. Well, Congressman, it's an issue somewhat outside of my ken. In looking at the terrorist threat, I would say, when one focuses back on 9/11, all of the 19 hijackers entered the country, firstly, legally and withproper documentation. So certainly you're right in pointing to the threat that illegal aliens and undocumented people have, but I think the threat is even much wider than that.

Mr. SHAYS. But isn't it the responsibility of the National Government to defend its borders. And we have a visa process and so on that let's us know who is here and who is not. People here illegally are here without our knowledge. Doesn't that strike you as somewhat absurd to then suggest that we have the capability to deal with a potential terrorist threat?

Mr. HOFFMAN. I think the lesson that 9/11 teaches us is that we have to have the kind of dynamic and flexible approach that can deal at multiple levels.

Mr. SHAYS. Let me ask you, those in the hospital, how is it that we need to be able to deal with a surge capacity when we are dealing in a sense with a surge of illegal immigrants? How do we sort that out? How does that fit into the equation? Isn't it a fact that illegal residents tend to use the emergency facilities of a hospital more than just knocking on—going through the regular process of interacting with a doctor? Unless we have, and we have expanded our community-based health care clinics, but without community-based health care—let me ask it this way. Aren't these facilities being overworked by the fact that we have illegal residents who are using these facilities?

Dr. LEWIS. It is not my impression that any significant part of the overcrowding or the use of the resources is directly tied to the illegal immigrants who work in Los Angeles County.

Mr. SHAYS. How would you know that? Do you find out if they're here illegally?

Dr. LEWIS. One often finds out when one is taking a social history and asking about family background, travel history, that sort of thing.

Mr. SHAYS. So you're under oath right now, and you're saying that, under oath, you do not believe that you have an overuse of these facilities by people who have no other ability to have health care, and that this is not in any way caused by illegal immigrants?

Dr. LEWIS. Let me just ask a clarifying question. When you use the term "overuse," do you mean any use?

Mr. SHAYS. Any use.

Dr. LEWIS. If you define any use of our emergency department by people who are in the country illegally, the answer is, absolutely, there is such use. If you mean overuse in the sense that the use is disproportionate because of their illegal status, I believe the answer is no.

Mr. SHAYS. I actually mean both. Why wouldn't it be? Logically it would seem to me to make sense that if they had nowhere else to go, they're going to go to the hospital. That's what we are encountering on our side in the East Coast. Every hospital tells me that you have an overuse in our emergency wards by people who simply have no other place to go.

Dr. LEWIS. I think that we're mixing a couple of different distinctions. My impression, and I have not collected data on this and I'm not prepared to give you numbers, is that most of the illegal immigrants when they have nonurgent medical conditions choose to seek care in a variety of outpatient facilities that are scattered around the city, and they don't actually want to come to the emergency department. The second, if I could just answer the second part of your question.

Mr. SHAYS. Make it shorter, though, please.

Dr. LEWIS. When you are told that a significant burden on the system is by people who have nowhere else to go, the majority of those people are legal residents or citizens of this country who have no place else to go because they don't have health insurance, not because of their legal status.

Mr. SHAYS. Thank you.

I yield the balance of my time.

Mr. ISSA. Thank you.

Dr. Lewis, I'll followup in this same area. And I agree with you as a fellow Californian that we can't have it both ways. We can't say that the uninsured seek emergency room care disproportionately because they can go there, they essentially are covered by the umbrella of last resort because they're poor and uninsured, and then not use the term broadly uninsured rather than illegal versus legal, etc. So, although I think illegal represents more than perhaps you're saying, I think it is appropriate, at least in California, to look at it in terms of the uninsured using the emergency room as essentially the guaranteed insured area for the poor and uninsured.

I'm concerned about this survey that was done. You participated in the survey. And UCLA Medical Center that day said that there were 14 patients boarded by the emergency department presumably waiting for in-patient beds to become available. How do you explain the fact that you had 14 in-patient beds available that same day? Wouldn't it be fair to assume that, to a certain extent, you could have made them all, you could have put them all in immediately if you gave them the highest priority? And rather, quite frankly, there has to be some credibility to the reserve for higher-paying accounts, wouldn't be that correct?

Dr. LEWIS. No.

Mr. ISSA. So you're saying that you had 14 boarded patients and you had 48 in-patient beds available and that—I'm trying to understand. Clearly you had beds available, and you could have shifted people into them, isn't that correct?

Dr. LEWIS. I believe that you are making a common misinterpretation of the information that was given to you, and I've seen the same information. It has to do with how one defines an available bed. To a hospital administrator, an available bed is a bed that is physically there; you walk in the room, there is a bed, and there is no patient in it.

Mr. ISSA. OK. So as a followup, what you're saying is you were not staffed to put people into those beds?

Dr. LEWIS. That's a very important distinction because the staffing is directly related to the level of hospital resources.

Mr. ISSA. And I just would like to followup.

Chairman WAXMAN. The gentleman's time is up, but did you complete your answer?

Dr. LEWIS. No. I was trying to make the point that the issue has to do with staffing. And therefore, when one is trying to get data on the number of available beds, especially in the setting of disaster preparedness, the important question is what number of beds are available or could be staffed in the next few hours. And I don't believe the questionnaire was clear in that regard.

Mr. ISSA. Mr. Chairman, I know you went on for a little while. This will be very short.

Chairman WAXMAN. The gentleman's time is expired.

Ms. Watson.

Ms. WATSON. Mr. Chairman, I think some of the questions that are being asked of the witnesses ought to be asked of the Members sitting up here who make the policy.

Dr. Lewis, I am so glad you're here. I am intimately familiar with the situation down in Watts, CA, and Martin Luther King Hospital. And when that hospital's Medicare funds were pulled and Medicaid funds were reduced, many of the patients that would have gone to King had to come to surrounding hospitals. They're overcrowded. And I know on the day of the survey, 33 of your ER patients were being treated in chairs or hallways. I have been in that situation myself in one of our most prominent hospitals waiting 2 hours and 15 minutes, and people had been there for 4 days. We have a critical problem in our community, in our county hospital system. And we probably have one of the largest ones in the State in the Los Angeles area. The day we took this survey, was that an unusual day for your hospital?

Dr. LEWIS. In reviewing the numbers, and I should clarify that I was not working that day, but in reviewing the numbers that were submitted, my impression was that was a slightly less busy than usual day. It was done on a weekday.

Ms. WATSON. Now, Saint Francis Hospital, you're aware of it?

Dr. LEWIS. Yes.

Ms. WATSON. Is a DSH hospital, and it, too, is complaining—Doctors Hospital. I can name all the hospitals in the area. I chaired the Health and Human Services Committee in Sacramento in the Senate for 17 years. I am intimately aware of our problem. What is it that we need to have a functional and comprehensive care system for the indigent? And I know you're not in the business of doing the work of immigration officials and seeking; you treat people as needed. What would you want to see in this Los Angeles County area, and maybe some of the rest of you in other States

would want to respond, too, that would make our system viable to care for the needy, to care for the people who come through your doors, regardless of whether they're there legally or illegally?

Dr. LEWIS. If I was limited to a single answer——

Ms. WATSON. Yes.

Dr. LEWIS [continuing]. My answer would be an increase in the number of available in-patient beds in the hospital that are staffed by qualified nursing personnel who are available 24 hours, 7 days a week.

Ms. WATSON. When Dr. Levitt—thank you for your response.

When Dr. Levitt cut the Medicare dollars from King, or from L.A. County, that was 50 percent of the resources. So it impacted all of not only the county hospitals but private hospitals as well. Staffing of emergency personnel, what would you like to see there, and you talked about other beds, but emergency and trauma?

Dr. LEWIS. The most pressing shortage that we have right now in Los Angeles County is related to nurses in the emergency department. There's a nationwide nursing shortage. The working conditions and the stress level in the emergency department makes it not a popular long-term career choice for the best nurses. And that is the most pressing immediate personnel need that we have.

Ms. WATSON. OK. How do we solve that problem, and I will ask that of all of the witnesses?

Dr. Welsh.

Dr. CONWAY-WELSH. I have several suggestions. The amount of Federal dollars that are available for nurses to go back to school and to become either BSNs or masters-prepared nurses is very, very limited. The faculty scholarship program is very, very limited.

Let me take a little bit different cut though on your question about what could be done. The School of Nursing at Vanderbilt has just received status as a clinic, a nurse-run faculty clinic, as an FQHC. That process took us almost 10 years to be designated as an FQHC. There are schools of nursing all over this country that close their clinics once their education dollars run out from HRSA because they can't maintain it because all of our patients are indigent and poor. An increase in the amount of FQHC support would be extremely helpful.

And then the last point I might make is that we have many, many nurse practitioners who are not able to practice in the full scope of their practice because of State problems with the Medical Practice Act and the Nurse Practice Act. We need a Federal preemption that would allow the current nurse practitioners to practice in the full scope of practice.

The other thing that we need to do is nurses are hunters and gatherers in hospitals. There's 30 to 40 percent of what they do that they shouldn't be doing. But the system doesn't allow them to give that up. There's not enough support of the non-nurse personnel for nurses to stop being hunters and gatherers. We would significantly address the nursing shortage in this country if we could just allow nurses to nurse and if we could fully utilize our nurse practitioners.

Chairman WAXMAN. Thank you, Ms. Watson.

Mr. Issa, you're now recognized for just 5 minutes.

Mr. ISSA. Thank you, Mr. Chairman.

Can I ask unanimous consent to submit eight documents into the record that reflect the Commonwealth of Virginia's emergency response preparedness, both alone and in conjunction with the rest of the National Capital Region?

Chairman WAXMAN. We'll review the documents before we're willing to give unanimous consent, and we'll see if we can get the unanimous consent.

Mr. ISSA. So you're reserving an objection?

Chairman WAXMAN. I object until I get a chance to review the documents.

Ms. WATSON. Mr. Chairman can we see the documents, too? I don't want to vote unless I know what it is.

Mr. ISSA. Mr. Chairman, here are the documents.

Dr. Lewis, because I ended the last round, I was just going to comment that in your own statement, you had said that you had surge capacity; you could bring in people that you wouldn't otherwise have, but it would put you into the red. And I'm not going to further elaborate because of the shortness of time, but if you have 48 beds and you don't fill them and 14 people say boarded, to me it sounds like you were unwilling to go into the red in order to board those people. But you did have 48 capacity, assuming those higher cost resources were available, but your hospital chose not to do it that day.

Dr. Kaplowitz, I'm very intrigued by your testimony, these documents that are pending going into the record. If I understand you correctly, if there were a significant crash or something on the Orange Line or Blue Line today representing dozens or even maybe 100 significant injuries, you would be prepared to put together the resources to take care of that. Is that correct?

Dr. KAPLOWITZ. We would be working very closely with the District of Columbia and Maryland in terms of appropriate distribution of patients working through EMS as well as the hospitals. We would activate our Northern Virginia coordinating hospital, which is at Innova Fairfax, and do the best we can for optimal distribution of patients. I can't tell you what would happen. You know, first of all, that could be anywhere.

Mr. ISSA. Sure, I understand on a given day that you can't answer. But in general, and we'll go back to Virginia Tech. Virginia Tech was an example of the worst of all worlds, a place you didn't expect it, a weather condition that wasn't cooperative and hospitals that generally were not prepared. And yet the response, looking back, you were able to rise using resources as you could transport people and/or—people one direction or the other. Is that correct?

Dr. KAPLOWITZ. Virginia Tech was not truly a mass casualty event. It stressed rural hospitals. And we were prepared to pull in people. However, no hospital was pushed beyond what they were capable of doing and wasn't hundreds of people at the same time.

Mr. ISSA. And, Doctor, I know it's always unfair to do hypotheticals, but in general, the amount of times that America is going to be attacked in mass by a dirty bomb, chemical attack or aircraft from the sky, compared to the amount of time in which an airplane crashes as it is landing in Iowa, a DC–10, the Blue Line does have an electrical failure and people are damaged or burned, a gasoline truck on the 405 jackknives and bursts into flames, a

fire in a refinery, such as Long Beach, a widespread hurricane or tornado that injures many; aren't all of these dramatically more likely? And I'll be self-serving and say, since it happens every year in America, every single year one or more of these, actually almost all of them happen at least once or twice a year, mass casualties occur every year in America. Isn't it true that, in fact, if we take the war on terror, the likelihood of another attack like 9/11 completely out of the scenario, that the need is greater in frequency and even likelihood of dozens or hundreds of people needing care, isn't it greater based on these? And I will throw in just one more for good measure, Dr. Lewis, an earthquake in Northridge?

Dr. MEREDITH. Yes, it is, and we're not ready to deal with that. Whether you survive an injury in America today on Interstate 40 from Wilmington, NC, to Barstow, CA, depends on how well you get hurt and how well the trauma system is organized between those two points.

Mr. ISSA. And, Dr. Kaplowitz, I'm particularly intrigued because you seem to be positive in saying that, at least within the resources available, Northern Virginia and Virginia in general has done a good job of being prepared. And I'm particularly concerned because I'm a Californian, and it appears as though California feels they're not prepared. Could you comment further on why you feel fairly prepared within the resources available?

Dr. KAPLOWITZ. Preparedness is all relative. We've put a great many things in place to go beyond where we were on 9/11. I can't tell you how we would handle hundreds, you know, whether people would be happy with how we handled hundreds. We would have a plan, a communication system.

Mr. ISSA. One final question for the panel. If I had a billion dollars sitting in the center of this room and I gave it to you for preparation, training for these mass events or I spread it around the country to staff up or reimburse Medicaid, which would you rather have that billion dollars go to, assuming there was only one pile of $1 billion available today?

Dr. KAPLOWITZ. I would like to see our emergency departments and our capability, able to function on a daily basis. Because much as I've talked about surge, I also agree that if we don't do a better job on handling emergencies on a daily basis, we're going to be at a disadvantage when there is a mass casualty event. We have to be able to empty our emergency rooms more rapidly because that's going to be even more important in an emergency event. Again, I'm positive in terms of what we've put in place in the kinds of communications. However, I recognize full well the stresses on our emergency system on a daily basis, and we can't ignore that. They're interrelated.

Mr. ISSA. Mr. Chairman, I would appreciate it if the others could answer for the record which way they would spend the money or if you would like to give them additional time.

Chairman WAXMAN. Well, whichever of you want to respond.

Yes, Dr. Lewis.

Dr. LEWIS. I agree absolutely with what Dr. Kaplowitz said. But in addition, I would like to point out that even if one chose to spend the $1 billion on training and equipment and things that would only be used in those very unusual events that you pointed

out, one of the key decisions is whether we want to be prepared for the most likely of those catastrophic events or whether we want to instead be prepared for the least likely, meaning bioterrorism or nerve agents.

Mr. ISSA. Good point.

Dr. CONWAY-WELSH. I would take the $1 billion and apply it to the public health infrastructure in our country. That is critical to any kind of a response in any kind of a disaster. And we are in grave danger of a really crumbling public health infrastructure in our country.

Dr. MEREDITH. You could fund the Federal infrastructure to support the States to develop trauma systems for $20 million or $10 million—million, million dollars. You know, you'll drop that on the way to work in the morning. So that should be done.

The next piece is just to your question, Representative Issa, can we plan to surge on a daily basis and always be ready nationwide? I don't think that is do-able or the smart way to do it. But I do think we are not ready on a daily basis to do what we have to do every day. And that frightens me immensely because we're not prepared for the bomb in a cafe or the mall or a bus falling off a bridge because we don't have the capacity on the every day basis.

Mr. HOFFMAN. This isn't exactly my expertise, but I would say that I agree completely with Dr. Lewis' statement. And I would point out that as unlikely as a terrorist attack may or may not be in the future of the United States, I think that the American people would expect that, years after 9/11, we would be prepared adequately to respond to any kind of threat like that.

Chairman WAXMAN. Thank you. And of course, they would expect we're not going to make things worse by Medicaid cuts.

Ms. Norton.

Ms. NORTON. Thank you, Mr. Chairman.

And I must say, because I represent the city, I'm especially grateful that you brought some sunlight to this really urgent problem as we face Medicaid cuts. I want to note that I have constituents from Anacostia High School who would be very much affected if in fact there was such an event here.

Mr. Chairman, since 9/11, I've been trying to get funds out for what are called ER–1. It was to be a demonstration here. People came from hospitals all over the country to see how we did it here and then to see if they could replicate it. And essentially it would add to the Metropolitan Hospital Center a surge capacity and a way to quickly add on that capacity.

I want to—my concern, I will say to the panel, is that you have a mix of residents here. So if you try to separate out who you're talking about, undocumented, poor, who overuse, of course, emergency rooms from the ordinary emergency, you're going to have a hard time, which is why this ER–1 notion was to try to say this is the place, it is close to the Capitol, to send trauma victims. We have a burn center, for example. They brought people there from Virginia after 9/11. On top of 600,000 people who live here, we've got 200,000 Federal workers and other workers who just come in every day and go out, creating a potential for a true catastrophic situation. They won't be able to get out on the roads. Some of them

will try to get out if they are hurt. So the point is to let them know quickly what the place is to go.

Now, Virginia, and Dr. Kaplowitz you testified about what Virginia is trying to do with what money it had, and that caught my attention, placing key, according to your testimony, key supplies and medications in various places. Of course, Virginia went through 9/11 and trying to deal with surge in its various hospitals. I would like to ask you, and then that inclined me to look at how much in Medicaid funds Virginia would lose to see whether Medicaid funds were implicated. And I learned that Virginia—and when we talk about Virginia, Maryland and the District of Columbia, we're talking about one place virtually, except that if the event occurred here, unlike the Pentagon, if the event occurred here in this crowded space and people went to various hospitals, you would only make the situation worse, which is why we're working on this ER–1. The administration has supported it. We have not been able to get it through appropriations, even though they found considerable support for it.

Virginia would lose $93 million in Federal Medicaid funds over the next 5 years. I'm trying to discern what impact the loss of Federal Medicaid funds would have on the surge capacity they're trying to create out of whole cloth.

Dr. KAPLOWITZ. I've been thinking about that, knowing I was going to be here today. I know you've heard from Dr. Sheldon Retchin, who spoke about the impact on the VCU health system. Again, if we lose much of the capability to handle emergencies on a daily basis, it's going to definitely put us at a disadvantage.

I know full well how much Level 1 trauma centers depend on Medicaid funding in general, not only for trauma care but in general, whether it's the VCU health system or Innova Fairfax. And I'm very, very concerned of the impact it's going to have on the ability of those facilities to function, not only in an emergency but on a daily basis. And they do work together. It's hard to expect a facility to add surge if they're to stressed on a daily basis. Nonetheless, we are planning for surge capability, surge beds for an emergency no matter what the situation is on a daily basis. We have to plan for the emergency and recognize that there are stresses on a daily basis. So I know there's going to be enormous impact on a number of facilities, especially our Level 1 trauma centers on a daily basis. It will impact their ability to surge in emergencies. That's not going to stop us from continuing to plan for that large event looking at distribution of patients and hoping facilities respond appropriately.

Ms. NORTON. Level 1 trauma centers are the ones that, because they are the hospitals that have the greatest capacity, tend to be the ones that are overcrowded?

Dr. KAPLOWITZ. Absolutely. There's one other point here that's not related to Medicaid funding but related to surge. And that is the concern that hospitals have of the funding they're going to receive after an emergency. I bring this up because it's a major issue when hospitals are talking about surging in emergencies. Most hospitals, most health care is private. And there's been a lot of discussion and stress about what kind of reimbursement they would get

in responding to emergencies. They're going to respond, but are they going to be dramatically hurt financially?

Ms. NORTON. Following 9/11, it was easier to get funds out after the fact, and this is what's so frustrating to me. Because in the face of a catastrophe and living in a country that doesn't prepare for anything, money went out. But preparing for such an event is very bothersome. I am concerned, and I would like finally to ask this, if in fact these patients are distributed to the trauma centers wherever they are in a place like the District of Columbia, rather than to have a place that is specially outfitted to deal with traumas, if you would tell me how an emergency room is supposed to decide how to quickly separate the traumas that come, let us say from the District of Columbia, the other people who have serious emergency problems who come in, the people who shouldn't be in the emergency room but perhaps should be referred? I mean, I'm worried about the chaos of just sending everybody to trauma centers in the first place.

Dr. Meredith, did you have an——

Chairman WAXMAN. The gentlelady's time is expired but we'll get an answer to the question.

Dr. MEREDITH. The trauma center itself is designed to do that exact question. A lot of work has been done to define what kind of patient is the trauma patient and how should they move. And those questions are answered. There are about 230 Level 1 trauma centers and about 320 Level 2 trauma centers, so we're talking about saving 550-ish maybe between that and 600 hospitals that are a core of the safety net for patients in the country.

Ms. NORTON. Thank you.

Mr. Chairman, I want to just say I'm very concerned that if people simply go to the hospital closest to them as opposed to the hospital that in fact has been most prepared to handle the surge from the event, all of the placement that Virginia is trying to do for example, kind of a little bit everywhere without Medicaid funds, will not serve us well in the event of a truly major capacity. If I may say so Virginia was not the kind of event that we in the District of Columbia are most afraid of following 9/11.

Chairman WAXMAN. Thank you, Ms. Norton.

I want to ask this. We have a health care system in this country that's the most expensive in the world, and yet we have 47 million people who are uninsured. Most of them are working people, and they don't have insurance. So if they get sick, they go to the emergency room. If they don't have insurance, the hospital doesn't get paid for the care that they're given. So hospitals then have to figure out how to survive economically without getting paid for a lot of these emergency room patients. Isn't it true that the people that are in hospitals today because of this whole crazy system we have are some of the sickest people, unlike in other countries where they're not the sickest, they're not the ones that you just can't deny hospital care, but in our country, it's the sickest?

Is that right, Dr. Meredith, do you know.

Dr. MEREDITH. I don't know. It's a hard system to figure out, and I work in it every single day.

Chairman WAXMAN. Well, it's a hard system to figure out. But let's look at the system. There's not enough money in the system

for all the people who use it who don't have health insurance coverage.

Now, does it make any sense—Dr. Hoffman, does it advance the goal of Homeland Security for the Federal Government to then be withdrawing funds from Level 1 trauma centers, whether through the Medicaid program or some other funding source? Is it reasonable for the Federal Government to assume that States and localities are going to make up these losses to the hospitals or the market forces will make up for the short fall?

Mr. HOFFMAN. Mr. Chairman, you know, I think we've already learned the lesson of not being adequately prepared before 9/11, so, no, it doesn't make sense from my perspective as a terrorist analyst.

Chairman WAXMAN. As a terrorist analyst.

How about those of you who are in the medical field? Does it make sense when you're struggling to keep these hospitals going under ordinary circumstances and trying to find out how to fund them for the Federal Government to withdraw Medicaid funds?

Dr. MEREDITH. Market forces will not make up for the loss that this money represents to the safety net hospitals and to these few trauma centers, I'm certain, because of the way the patients are moved around now. They will still get those patients. And when it represents such a loss that they can't sustain it, they will stop being trauma centers, and we'll lose them from the system, and it will be tragic.

Chairman WAXMAN. A lot of hospitals are already closing their doors for the emergency rooms because they can't afford to keep them open.

Dr. Kaplowitz, you're trying to find out how to plan, you're trying to plan for an ordinary catastrophe or a terrorist kind of catastrophe. Does it help your planning efforts when the Federal Government withdraws money from the Medicaid program or some other funding source?

Dr. KAPLOWITZ. Not at all. And as I mentioned already, we're very grateful for getting some funding for emergency planning. But that's only a fraction of the funds hospitals receive. It couldn't then begin to replace the Medicaid dollars or the other dollars they need to maintain their infrastructure. So absolutely it makes no sense at all to lose that much funding.

Chairman WAXMAN. Now, some people say disasters are local. Local communities need to prepare for a terrorist bombing or similar attack. But it's also true that the Federal Government has a responsibility here, which starts with at least doing no harm. And that means not withdrawing Federal Medicaid funds that now support Level 1 trauma centers in the highest risk cities. I wanted to pursue another point about how we prepare for a terrorist attack. There has been, Dr. Hoffman, evaluations of potential terrorist attacks. In fact, I think the Centers for Disease Control brought together a panel. Is it the consensus of people looking at possible terrorist attacks, if we're going to have one, it's going to be using conventional weapons rather than a weapon of mass destruction?

Mr. HOFFMAN. Absolutely. Again, I don't think we can rule out any potentiality. But certainly the higher probability event is conventional explosives and perhaps with suicide attacks.

Chairman WAXMAN. In fact, according to the CDC report that was produced, they said a terrorist bombing attack in the United States would be a predictable surprise, like a hurricane is a predictable surprise, or a major automobile traffic accident could be a predictable surprise. Yet the Federal Government, under existing law, has a responsibility for developing national medical surge capacity to respond to a mass casualty event, such as a terrorist attack with weapons of mass destruction. Last October, the President issued Homeland Security Presidential Directive No. 21, which established a national strategy for public health and medical preparedness for this kind of an event. It's crucial that we be prepared for an event using a dirty bomb or biological weapon. But I don't know that there's any national strategy to prepare for or respond to a terrorist attack using conventional explosives, such as happened in Madrid or here in Oklahoma City or at Centennial Park in Atlanta. Dr. Hoffman, is there such a Federal response being prepared by this administration that says, the buck stops here?

Mr. HOFFMAN. No, my understanding is that incidents like terrorist attacks involving conventional explosives are viewed to a lesser included contingency, and the assumption has long been, going back from what I testified before a subcommittee of this committee that Congressman Shays chaired nearly a decade ago, is that generally these more conventional types of terrorist attacks don't receive the same type of attention that the high end, less likely threats do.

Chairman WAXMAN. Well, this is exactly what we want to ask the Secretary of Health and Human Services and the Secretary of Homeland Security. What is the Federal Government doing? What do we have in place? What are we planning in case a predictable event such as a terrorist attack occurs. And some people think that's partisan to ask those questions. I think it is something we ought to be asking on a bipartisan basis.

Mr. Shays.

Mr. SHAYS. Thank you. Dr. Hoffman, Hadassah Hospital in Jerusalem has a facility that has a whole floor designed for a surge capacity, but they have no doctors to man it. In other words, it's—and it is there for a potential chemical attack, and so on, where they can isolate patients and so on. I see the logic of doing that, but I don't see the logic of staffing it. And so then they compromise and they bring other people in from different places. Isn't that a model that makes sense for the United States?

Mr. HOFFMAN. Well, sir, I used to think I was in a depressing field studying terrorism until I sat on this panel with my distinguished colleagues. And given everything that I've heard about the capacity of our trauma centers this morning, it's a different situation.

Mr. SHAYS. I don't know why it's different. They have to deal with a terrorist attack and that's what we're talking about right now. I mean, you know, Dr. Lewis, your hospital was kind of shut down for a while because they required you to have more people present. I mean the requirements changed and so it took a while to get back up to speed because of, I think, new regulations; is that correct?

Dr. LEWIS. I don't believe our hospital was shut down at any time.

Mr. SHAYS. I mean—you know what I'm making reference to. Do you want to explain it?

Dr. LEWIS. Actually I'm not sure. Are you talking about a citation we received in response to long waiting times in the emergency department?

Mr. SHAYS. Right. I meant only—I'm sorry, I didn't mean hospital, I meant in the emergency room. This is not a trick question. I mean, the point that I'm trying to make was that you had to staff it at certain level and you weren't able do that, correct?

Dr. LEWIS. The citation was in response to delays in seeing patients with acute medical conditions because of the long waiting time in the emergency department.

Mr. SHAYS. Right, but——

Dr. LEWIS. Let me try to answer your question. The staffing was simply a way of more quickly screen—additional staffing to screen those patients.

The question you asked about how Israel is different, one very important way that Israel is different is that because of the constant concern over mass casualty incidents they do not allow their emergency departments to become overcrowded. And one way they accomplish that is that if the emergency department becomes overburdened they immediately move those patients up into non-normal treatment areas inside the hospital so the emergency department does not get gridlocked. And that's a reflection of their greater day-to-day awareness of this threat.

Mr. SHAYS. So but the bottom line is they have a surge capacity in space, not necessarily in terms of doctors on duty and nurses on duty. And it would strike me that's part of the model. It would strike me that part of the model that we have to work on is better coordination and how we move patients and so on. And we're connecting two things that maybe need to be connected. But in the process we're really talking about two separate issues. One, do you have the capability to deal with your basic emergency needs day in and day out? I mean I'd love to know—I'd love to keep going because I'd love to know is there a rule of thumb with so much population you need a trauma 1, a trauma 2 and a trauma 3. Some States may not have it. I think West Virginia doesn't. Is there—should every hospital have an emergency facility? And I understand that some don't now. You know, so those are all legitimate, you know, questions that I have no answer to.

Dr. LEWIS. I'd just like to comment that there are standard rules regarding for a population of a given size the number of inpatient hospital beds. Prior fiscal pressures have forced many hospitals to reduce the number of inpatient beds that they either maintain physically or maintain staffing for. So fiscal pressures over the last 10 or 15 years have resulted in most or at least many metropolitan areas having a number of inpatient beds far below the originally recommended number.

Mr. SHAYS. Right.

Dr. LEWIS. That's the direct cause of the ED overcrowding that we've been talking about. So there are rules of thumb and we violate them.

Mr. SHAYS. But what would be a shame in this process is I happen to have opposed the changes in requirements. And we voted to try to hold them, but what would be a shame would be to not be having the dialog about all the other things that don't take money necessarily, but talk about coordination, which we're not even getting into.

Dr. Kaplowitz, my understanding is Virginia does a better job of anticipating these kinds of challenges.

Dr. KAPLOWITZ. Well, we've had to out of necessity but I wanted to make the comment about Israel. I've been there. Israel provides health care coverage for everybody in their population.

Mr. SHAYS. Right.

Dr. KAPLOWITZ. Their facilities are not under the same financial stresses as ours are here. Not only do they deal with suicide bombing, but every single one of their hospitals is a hospital when they have a war. It's a different mindset, but the fact that everybody has coverage, everybody has a medical home, it's made an enormous difference in terms of their emergency preparedness and the stresses on their individual hospitals.

Mr. SHAYS. Let me just end with this comment. First, one area where the administration doesn't get enough credit is the effort they have gone with community-based health care clinics. We've expanded from 10 million to about 16, 17 million people covered. That's one area where they do deserve credit. And there's areas where they, you know, rightfully should be criticized.

I happen to be on legislation cosponsoring with Jim Langevin that says we're going to go to universal coverage giving—providing the same health care benefits that Federal employees have as a choice to everyone. Where I have my big disconnect, and it seems like it's an issue we don't want to ever discuss in this country, is how we deal with the 13 to 20 million people who are here illegally. They are not undocumented. Undocumented means that somehow all they have to do is be documented. By not being documented they are here illegally and they are here illegally. And it doesn't seem to come up. And I know for a fact these are folks that don't have coverage and intuitively they are going to go wherever they can get help and they are going to go to emergency wards. And the fact that we like want to dance around this just blows me away.

That's my comment.

Dr. KAPLOWITZ. I did want to make a comment about a public health study that has shown that recent immigrants actually used less medical care than the rest of Americans. This was brought up in the recent series about disparities in care. So while I acknowledge that there are significant numbers of people who may we here illegally, they actually used less medical care than——

Mr. SHAYS. And let me tell you why I think that is an irrelevant statement. They use less care and when they do use it they go where they can get it, which is an emergency ward. And therefore the logic is that when they do use it, they are using it there.

Dr. KAPLOWITZ. They——

Mr. SHAYS. Thank you.

Dr. KAPLOWITZ. I will add another comment. They are not only going to emergency rooms. I'm on the board of a free clinic—free

clinics—an enormous amount of care, including to undocumented persons. So they don't all go to emergency rooms.

Mr. SHAYS. They go to community-based health care clinics, we know that, and that's one thing the administration has done well.

Chairman WAXMAN. I want to raise a point that I think this issue of illegal immigrants is a red herring.

Mr. SHAYS. Why?

Chairman WAXMAN. The reason it is a red herring is that illegal immigrants are not eligible for Medicaid, they are not eligible for Medicare. They may get private insurance, and if they do, their insurance company is paying the bills based on their payment to the insurance company.

Mr. SHAYS. But isn't that——

Chairman WAXMAN. I'll take a time and then I'll let you take a time.

Mr. SHAYS. Thank you. OK, no problem.

Chairman WAXMAN. I'm not going to get interrupted.

So when the people who are illegal come to an emergency room, it's usually as a result of a trauma.

Dr. Lewis and Dr. Meredith, from your experience and knowledge of what goes on in emergency rooms, are most of the people in emergency rooms for trauma undocumented aliens or are they people that don't have insurance coverage when the hospital ends up with a bad debt?

Dr. MEREDITH. Most of the people in the emergency departments are not for trauma, they are for other emergency conditions. Trauma is very important to me, but a smaller part of what goes on in emergency departments. Most of the patients who are trauma patients are not undocumented or illegal, they are a spectrum of American civilization. They—everybody gets hurt, and they are a complete spectrum of people, a complete spectrum of people. We take care of them all. We just stop their bleeding, that's all we can do.

Chairman WAXMAN. Dr. Lewis.

Dr. LEWIS. I agree with the statement, trauma is a nondiscriminate force and it doesn't ask you about your legality status before you get hurt.

Chairman WAXMAN. Now, let's say Dr. Meredith rightfully pointed out that emergency care is not just trauma care. So someone gets sick, and they don't know where else to go, and they don't have health insurance and they end up in an emergency room. Of course that's the most expensive setting for people to get health care, which is one of the problems in our non-system of health care in the country. People get seen and treated in the most expensive way. They could go to a community health clinic.

When you see people who come in because they have no health insurance with a minor problem, do they get something extraordinary? Do they get a lot of time and attention which will encourage them to come back with these smaller problems?

Dr. LEWIS. It is my impression that the—if we're focusing specifically on illegal immigrants in Los Angeles County who come to my hospital, my impression is that the vast majority have attempted to seek care in other facilities first for the same problem, except for acute serious illness that couldn't be treated anywhere else. And

occasionally they find that the community health clinics, some of which are federally supported, some of which are just free-standing, have been unable to take care of their problem because it has either gotten worse despite treatment or there has been some complication. But it is my impression the vast majority of them attempt other avenues for seeking medical care before they come to my department.

Chairman WAXMAN. Now there are 47 million people without health insurance. I've heard an estimate that there may be as many as 5 million illegal immigrants. Now 47 to 5, of those 5 million illegal immigrants, some of them have health insurance, isn't that true? They have a job where they are provided health insurance, probably most of them don't. And if they need health care, they'll go to a clinic. It's the right thing to do for us to have put in more money into the community health centers programs. But it doesn't deal with the problem that we have. Let's say 47 plus 5, 52 million people. Yet if something terrible happens to them they have to go to get care immediately, they are not going to go to a clinic, they are going to go to an emergency room.

What should the Federal response be for emergency rooms that are facing 47 plus 5, 52 million people without insurance? Well, the hospitals can't turn them away. Well, what most hospitals do if they are private hospitals they will close their emergency room. And then if they don't have an emergency room, these people have to go to places where there are emergency rooms. But if those emergency rooms are already overburdened, they are diverted to other emergency rooms. Isn't that what happens?

Dr. LEWIS. Yes, that's correct. And although I don't have a good suggestion for what the Federal Government should do, what I am sure that it should not do is reduce the funding for those safety net hospitals prior to having a viable alternative solution.

Chairman WAXMAN. And certainly they shouldn't do it without finding out what the consequences are. That's what's so shocking to me about these Medicaid cuts. The Center for Medicaid Services and the Department of Health and Human Services never even did an evaluation of what the impact would be if these kinds of cuts took place. They simply said we'll let the States and local governments figure out how to deal with this.

Well, it seems like they are trying to make the States and local governments have to deal with everything. And at least when it comes to a terrorist attack there certainly ought to be a Federal responsibility. I believe there ought to be a Federal responsibility for all people in this country who don't have access to health care because this is distorting our whole health care system. So that's why I say it is a red herring to say the problem is all these illegal immigrants. It's not just that. That's an over simplification and a diversion from the much more serious problem that this administration for 7 years has not given us any ideas except maybe give a tax break—which is inadequate to even buy health insurance—to a lot of people who couldn't then afford to buy health insurance even with that tax break.

Mr. Shays, I will recognize you for the last 5 minutes, and then we will continue.

Mr. SHAYS. Thank you. And I would be happy to have you interrupt me if you'd like—I mean to ask a question.

Chairman WAXMAN. No, I will not interrupt you.

Mr. SHAYS. What I'm looking for is meaningful dialog. I don't have any dog in this race. I mean I'm just trying to understand something. And I get confused because in the Medicare Modernization Act funds were included for hospitals in States with high numbers of illegal immigrants because these hospitals complained about the problem of illegal immigrants who were in fact stressing their hospitals. So you know——

Chairman WAXMAN. In the Medicare——

Mr. SHAYS. In the Modernization Act.

Chairman WAXMAN. Do any of you know whether that's accurate, because I don't believe that's accurate.

Mr. SHAYS. The question I have is first off, I do not believe that this is the cause of the problem. I think it is a part of the problem. It is news to me that if we have anywhere from 13 to 20 million people there illegally, that only 5 million don't have health coverage. That's news to me. And we have 13—we have 12 million people who are here legally who are documented, but not citizens. We have a range between 13 and 20 million who are not here legally. They are here illegally and I make an assumption, maybe incorrectly, that a majority don't have health care. Because it would really be surprising to think that 85 percent of Americans have health care, but you know undocumented workers have that same average or even half that.

I happen to believe that we need to have universal coverage. All I want is an answer from folks who are there that my understanding is you got two options for someone without health care. You go to a community-based health care clinic or you go to the emergency ward. I mean, I don't know if there are other options. And so it strikes me that we are stressing the emergency rooms. And they are hugely costly. I went where I had three stitches. The hospital got into a dispute with the insurer and sent me a bill for 1,300 bucks for three stupid stitches. Had I gone somewhere else it wouldn't have been obviously that expensive.

And so I'm just trying to make the point to you, Henry, that I think that we spend a fortune on health care, far more than other countries, and that we keep saying well, we just have to spend more money. We're at 18 percent of our gross domestic product and I don't think we can actually find a lot more money. And so what I struggle with is are there things that don't involve money where we can deal with the surge capacity.

And Dr. Hoffman, you didn't seem to want to jump in on some of this, like all of a sudden this was outside your expertise. But it strikes me that we can learn from what other places do. And they don't put a lot more money in, they have extra bed space with no doctors.

What I was confused by Dr. Lewis in the dialog with Mr. Issa, you said, well, we have 45 beds, but they are unmanned. Is that a bad thing that they are unmanned? Is it good that you have this space in case you have a need for surge capacity?

And another question I ask all of you, aren't there times when we're going to have to break the rules of so many nurses and so

many doctors when you have an emergency. Then it seems to me you throw it out the window, you may have doctors working overtime, nurses working overtime and some rules being broken during a surge—a needed surge.

Dr. LEWIS. First of all, I agree with you 100 percent that there are issues of coordination and response to major, very infrequent events that could be used without substantial funding to improve our ability to respond. I think there's no question that is correct.

The issue regarding the unstaffed beds in the hospital has something to do with the funding source. We're a publicly funded institution. The vast majority of our funds either come from or come through Los Angeles County. These are public funds. Such—the similar kind or type that you're responsible for administering.

Our hospital administrators cannot make a decision to go over their budget and staff those beds. It is not their authority. It is a public process that's overseen by the board of supervisors, who I understand were here recently. So it's—I got the impression or the implication was made that a hospital administrator was not staffing them to avoid losing money. That's not the case. It is just not an option.

Second, with respect to the money that is already being spent in preparedness, I think a number of us have tried to point out the disconnect between the most likely unusual mass casualty incidents and the types of incidents that seem to have been focused on by the existing hospital preparedness program. That program used to have the term, I believe, bioterrorism in its name. They took out the bioterrorism part of the name, but still maintained most of the focus on supplies and equipment that are related to relatively unlikely events.

So one thing that we can do without asking for additional money is to focus on the most likely events, and I'm not talking about the everyday surge events, the most likely true mass casualty incidents.

And then last, I'd like to simply point out that in Los Angeles County the public funds that support our institution, part of them come from tax revenues. Those tax revenues are driven by the economic activity in that area. I'm in no position to speculate regarding what the effect of removing those illegal workers would be from our economy, but I'm not actually sure that the net effect on the funding of our health care system would be beneficial. I actually think it would probably be detrimental. Clearly a health economist would have to look at that, hopefully one not driven by partisan concerns.

Chairman WAXMAN. Thank you, Mr. Shays.

Ms. Watson, did you——

Ms. WATSON. I sure do. And I just want to say, I don't think it's really clear to some Members that if you are an illegal immigrant you are not eligible, you're not eligible for Medicare and Medicaid.

As Dr. Lewis astutely notes, there are some Federal policymakers who still do not see the relationship between maintaining robust emergency and trauma care capacity and a successful homeland defense strategy. Hello.

I would like to ask Dr. Hoffman and Dr. Kaplowitz, both of whom know a great deal about emergency preparedness and response, to

help us connect the dots. While there is much dispute about whether the Medicaid regulations are justified, there's no dispute that they will reduce the amount of Federal Medicaid revenues to Level 1 trauma centers and other hospitals throughout the country.

There is also no dispute that the loss of Federal funds will vary from hospital to hospital and that for some Level 1 trauma centers these losses will be substantial, potentially forcing reductions in services and degrading their emergency response capacity.

So Mr. Hoffman, does it advance the goal of Homeland Security for the Federal Government to be withdrawing funding from Level 1 trauma centers whether through the Medicaid program or some other funding source? And is it reasonable for the Federal Government to assume that States or localities will make up these losses to the hospitals or that market forces will make up for the shortfall?

Mr. Hoffman—Dr. Hoffman, excuse me.

Mr. HOFFMAN. Well, I think certainly not in those cities, for instance, that the Department of Homeland Security have identified at least the most likely threat of a terrorist attack.

Ms. WATSON. Excuse me, when you say most likely those areas, how do you define the areas that are most likely the target of terrorist attacks?

Mr. HOFFMAN. Well, the Department of Homeland Security and also private risk management firms have assessed on a variety of indicators in terms of terrorist interests, in terms of the vulnerability facilities in those cities, which cities in the United States would be more likely than others perhaps.

Ms. WATSON. Would you consider the West Coast or Los Angeles area?

Mr. HOFFMAN. Certainly Los Angeles and southern California. San Francisco probably falls into that category as well.

Ms. WATSON. OK.

Mr. HOFFMAN. I mean given the pattern of terrorists, and certainly since 9/11 there is a very high concentration of these activities, fortunately not yet in the United States but overseas in major cities that are at least if not the capital of their nations, then at least are business centers or transportation hubs.

Ms. WATSON. I just wanted to hear your response. Thank you.

Mr. HOFFMAN. But if I could just finish for a second?

Ms. WATSON. Yes.

Mr. HOFFMAN. I would go back to what Dr. Kaplowitz said about Israel, which I think is absolutely correct, is that their energy services are not as over stressed in terms of their personnel as it appears in the United States. London by contrast though I think is very similar to the United States in that respect with emergency rooms that have—that already are burdened by a health system with lots of people in urban areas coming into them. You can see the difference in the response of the London hospitals to the July 7, 2005 attacks. There I think the coordination was not as good, even though they had extensive drills and extensive training, the planning—the system broke down in essence because there were insufficient personnel on that because the systems themselves were stressed.

Ms. WATSON. Dr. Kaplowitz, as a State official you've been involved in a great deal of planning for emergency preparedness and response throughout Virginia. Does it help your planning efforts when the Federal Government withdraws funding from Level 1 trauma centers, whether through the Medicaid program or some other funding sources?

Dr. KAPLOWITZ. Not at all. I need those facilities to survive. And I know what kind of stress they are under on a daily basis. You remove Medicaid funding, it could be disastrous. We have seen any number of hospitals need to close their doors. The last thing I need is for any more hospitals to not be able to survive financially. And the stressors for trauma centers are enormous. The additional cost it takes to keep your trauma center open is significant. And these facilities are functioning with very small margins. So I need them to be able to function and stay open, and I need them to maintain their expertise in order to appropriately respond to emergencies.

I've been at the Health Department almost 6 years. In my prior life I was at the VCU health system for 20 years, including working in hospital administration, and I know what kind of stress that facility is under on a day-to-day basis. You take away significant Medicaid funding, it's going to be disastrous. And the sameis true of all trauma centers in the Commonwealth.

Ms. WATSON. Thank you for that.

Chairman WAXMAN. Thank you, Ms. Watson. And I want to thank this panel. I think you've given us a lot of good information, some of it quite startling, and I think we have to pay a lot of attention to it and ask the people in charge, the Secretary of Health and Human Services and the Secretary of Homeland Security, both of whom are going to be here Wednesday, how to respond to some of these concerns what the Federal Government is doing and at least find out whether we're doing harm with some of the proposals that are being pushed.

That concludes our hearing today—oh, yes, there was one item, Mr. Issa requested unanimous consent to put in documents. I have no objection. Does anybody?

Ms. WATSON. No objection.

Chairman WAXMAN. Without objection, those documents will be part of the record. We stand adjourned.

[The information referred to follows:]

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Governor Kaine, Mayor Fenty, Governor O'Malley Discuss Regional Security Issues with U.S. Department of Homeland Security

– Executives commit to continue regular meetings –

RICHMOND – Virginia Governor Timothy M. Kaine, Washington, D.C. Mayor Adrian M. Fenty, Maryland Governor Martin J. O'Malley, Acting Deputy Secretary of the U.S. Department of Homeland Security Paul A. Schneider and Federal Emergency Management Agency Administrator R. David Paulison joined in an hour-long teleconference on Friday designed to respond to a simulated disaster in the Washington area. The goal of the exercise was to provide the opportunity to examine issues of crises communication, information sharing and decision making across the National Capital Region.

"We all learned a great deal about how our government agencies must continue to work together to assure the safety of our citizens," Governor Kaine said. "Virginia, Maryland and the District, along with the Department of Homeland Security, have invested deeply in the region's security preparedness and we are committed to keeping our citizens safe in an emergency."

"Public safety and homeland security is the primary responsibility of any government," said **Governor O'Malley**. "Today's exercise between Maryland, Virginia, the District and our federal government is critical to making sure our region's first responders are prepared to respond to an emergency. I want to thank Governor Kaine, Mayor Fenty, Acting Deputy Secretary Schneider and Administrator Paulison for taking the time to participate in this exercise."

"Disasters don't start and end at the District of Columbia border," said **Mayor Fenty**. "Today's exercise was an excellent demonstration of the regional teamwork it will take to keep our residents safe in a real emergency. I look forward to continuing to work with the two Governors and the Department of Homeland Security on security issues in the future."

"The result of this exercise, a true joint effort between Virginia, Maryland, the District of Columbia and the federal government, makes our region better prepared by fostering teamwork and enabling a coordinated response to a large scale incident within the National Capital Region" said **U.S. Department of Homeland Security Acting Deputy Secretary Paul A. Schneider**. "The exercise represents a culmination effort on the part of the National Capital Region Senior Policy Group and I applaud all those involved."

"The department and the Federal Emergency Management Agency are dedicated to developing engaged partnerships with our colleagues in local and state governments, such as Virginia, Maryland and the District of Columbia. I am proud of the cooperation inside the National Capitol Region, especially the coordination and interaction between the governors, District and federal officials"

said **FEMA Administrator R. David Paulison.** "The results of this exercise are an indication of all the hard work done by everyone in the Region and I commend their efforts."

The National Capital Region, created and defined by Congress, includes the District of Columbia, Prince George's and Montgomery Counties in Maryland, and Arlington, Fairfax, Loudoun, Prince William, and Alexandria in Virginia.

Friday's meeting was the eighth involving the executive leadership of the three jurisdictions since April 2003. The regional meetings have allowed the executives and their staff members to form strong cooperative relationships in areas of mutual interest and cooperation, including homeland security, air quality, transportation, the Chesapeake Bay, and tourism.

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Print This Page

For Immediate Release

July 14, 2006

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Governor Kaine Hosts Governor Ehrlich, Mayor Williams at Regional Meeting

- Homeland security, anti-gang efforts, tourism on agenda -

RICHMOND – Governor Timothy M. Kaine, **Maryland Governor Robert L. Ehrlich Jr.**, and **District of Columbia Mayor Anthony A. Williams** (contact Vince Morris, 202.727-5011) .met in Richmond today to discuss ways in which the three jurisdictions can continue to work together to pursue common goals. The meetings among the three chief executives, which began in 2003, have resulted in improved regional cooperation in areas including homeland security, crime prevention, anti-gang initiatives, transportation, and tourism.

"I am pleased to host this first regional meeting of our administration with my colleagues from the National Capital Region," Governor Kaine said. "This is the sixth such meeting in the past three years between the elected leadership from Virginia, Maryland, and the District of Columbia, and I believe we have demonstrated that these discussions can dramatically improve our efforts for greater regional cooperation."

Governor Kaine led a discussion on homeland security in the National Capital Region and gang prevention efforts. "Working together on Homeland Security, we have created and fine tuned the National Capitol Region (NCR) approach to preparedness, which now is viewed as a national model," Governor Kaine said. "To varying degrees, each of our jurisdictions faces a challenge with gangs and gang-related crime. We continue to share ideas – and, more importantly, information – in our combined resolve to combat the spread of gang violence, and offer other alternatives for our young people."

Governor Ehrlich led the discussion on Chesapeake Bay remediation and the effort to track convicted sex offenders in the region. "Governor Kaine, Mayor Williams and I share a deep commitment to revitalizing the Chesapeake Bay and its tributaries and protecting our children from sexual predators," said Governor Ehrlich. "In Maryland, we have enacted the historic Bay Restoration Act to restore the Bay and passed 'Jessica's Law' to punish those who prey on our children. We will continue working with our regional partners to share best practices on Bay restoration efforts and sex offender enforcement. Maryland, Virginia and the District of Columbia have made considerable progress on both issues to date, and I look forward to partnering with Governor Kaine and Mayor Williams on even greater accomplishments in the months and years ahead."

Mayor Williams led a discussion on regional tourism and economic development and how these areas might be affected by an increase in certain crimes in the Washington area. He also led a discussion on the Chesapeake Nanotechnology Initiative. "The safety of our region's residents and visitors is of the utmost importance to leaders like myself and Governors Ehrlich and Kaine," said Mayor Williams. "We in the District welcome federal and regional resources that support our efforts to reduce crime. Our international tourism numbers have rebounded to pre-9/11 levels, but we certainly don't want these gains to be damaged by publicity about an increase in crime in certain categories in our city. In addition to the increased police patrols that the city's crime emergency declaration will bring about, I am asking all city agencies to focus their efforts on tasks that they can carry out to help combat crimes, and I am encouraging residents to get more involved in anti-crime efforts by attending neighborhood meetings, joining Neighborhood Watch and by providing information to the police. We are sending the message that crime prevention is everyone's business - not simply the police."

Recent successful cooperative efforts among the District, Maryland, and Virginia include the dedication and opening of the first span of the improved Woodrow Wilson Bridge, steps to improve the health of the Chesapeake Bay and the region's air quality, emergency response in the wake of the September 11, 2001 terror attack on the Pentagon, and the 2002 sniper attacks.

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Print This Page

For Immediate Release

March 27, 2007

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Governor Kaine, MD. Governor O'Malley, D.C. Mayor Fenty, DHS Sec'y. Chertoff Discuss Regional Security Issues

– Executives build upon previous regional meetings begun in 2003 –

WASHINGTON, D.C. – Virginia Governor Timothy M. Kaine, Maryland Governor Martin O'Malley, Washington, D.C. Mayor Adrian M. Fenty, and U.S. Secretary of Homeland Security Michael Chertoff met today in Washington to discuss the National Capital Region's progress and cooperation on homeland security issues. Today's discussion, which built upon an initial January 12, 2007 meeting between these three local elected leaders, was held at the John A. Wilson Building in the District.

The principals discussed homeland security grants requests for the National Capital Region, continued regional cooperation on public safety issues, and agreed to formalize a communications regimen among the region's top elected leadership to occur during the first hours of a regional public emergency.

"Governor O'Malley, Mayor Fenty, and I are pleased that Secretary Chertoff was eager to meet with us to help us continue to build on our shared progress on homeland security issues in the unique National Capital Region," Governor Kaine said. "Virginia, Maryland and the District have made significant investments in this region's homeland security preparedness, and each of us is committed to work every day with our local, federal, and private sector partners to keep our citizens safe in an emergency."

"Today's meeting provided an opportunity for Governor Kaine, Mayor Fenty and I to discuss the unique homeland security issues of the National Capital Region with Secretary Chertoff," said Governor O'Malley. "Building on our meeting in January, Governor Kaine, Mayor Fenty and I remain committed to ensuring that our region is adequately prepared and trained to deal with any emergency."

"This was a very productive meeting," said Mayor Fenty. "The District of Columbia isn't an island when it comes to safety. I am grateful that Secretary Chertoff recognizes the unique challenges we face as the nation's capital. And I look forward to continuing to work with our regional partners, Governors Kaine and O'Malley."

The National Capital Region, created and defined by Congress, includes the District of Columbia, Prince Georges and Montgomery Counties in Maryland, and Arlington, Fairfax, Loudoun, Prince William, and Alexandria in Virginia.

Today's meeting was the eighth meeting between the executive leadership of the three jurisdictions since April 2003. The regional meetings have allowed the executives and their staff members to form strong cooperative relationships in areas of mutual interest and cooperation, including homeland security, air quality, transportation, the Chesapeake Bay, and tourism. The 2003 meeting was the first between Maryland, Virginia, and Washington, D.C. executives in 12 years.

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Print This Page

For Immediate Release

January 12, 2007

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Governor Kaine, D.C. Mayor Fenty, Md. Governor-Elect O'Malley Discuss Regional Security Issues

– Executives commit to continue regular meetings –

WASHINGTON, D.C. – Virginia Governor Timothy M. Kaine, Washington, D.C. **Mayor Adrian M. Fenty**, and **Maryland Governor-elect Martin J. O'Malley** met today in Washington to discuss the National Capital Region's progress and cooperation on homeland security issues. Today's briefing and discussion was held at the Unified Communications Center in the District.

"Mayor Fenty, Governor-elect O'Malley and I look forward to continuing these regular regional meetings so that we can build on our shared progress in the National Capital Region," Governor Kaine said. "Virginia, Maryland and the District have made significant investments in this region's homeland security preparedness, and each of us is committed to work every day with our local and federal partners to keep our citizens safe in an emergency."

"The District of Columbia is the nerve center of America's homeland security apparatus," said Mayor Fenty. "Along with Acting Police Chief Cathy Lanier – a proven homeland security leader – I am committed to ensuring the safety of my constituents and the integrity of the nation's security systems," he said, concluding, "I am fortunate to have the able partnership of Governor Kaine and Governor-elect O'Malley in this ongoing effort, and look forward to working with them long into the future."

"I look forward to working in partnership with Governor Kaine and Mayor Fenty to improve regional homeland security in the National Capital Region," said Governor-elect O'Malley.

The National Capital Region, created and defined by Congress, includes the District of Columbia, Prince Georges and Montgomery Counties in Maryland, and Arlington, Fairfax, Loudoun, Prince William, and Alexandria in Virginia.

Today's meeting was the seventh meeting between the executive leadership of the three jurisdictions since April 2003. The regional meetings have allowed the executives and their staff members to form strong cooperative relationships in areas of mutual interest and cooperation, including homeland security, air quality, transportation, the Chesapeake Bay, and tourism. The 2003 meeting was the first between Maryland, Virginia, and Washington, D.C. executives in 12 years.

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Office of the Governor Timothy M. Kaine

Emergency Management
UPDATE
Issued Biweekly for the Virginia Emergency Management Community

Feb. 13, 2008

2007 year in review

Though Virginia did not experience any major hurricanes in 2007, Gov. Tim Kaine declared a state of emergency three times:

- A February ice storm hit the Commonwealth, bringing a quarter-inch of ice to parts of the state and causing power outages for more than 60,000 residents.
- A gunman opened fire on the Virginia Tech campus in April, killing 32 students and teachers and wounding dozens before killing himself, making it the deadliest school shooting in U.S. history.
- In June, a lightning strike to the town of Goshen's water pumps led to a water outage and boil water advisory for nearly 400 residents that lasted for three weeks.

EM Training: The Office of Training and Exercises conducted 366 courses and trained more than 8,400 students. Outside the classroom, Virginia residents completed 118,602 Independent Study courses. EM Training also developed and conducted 20 discussion- and operations-based Homeland Security Exercise and Evaluation Program events with more than 2,200 participants. The 2007 Virginia Emergency Response Team Exercise was a four-day training event and included more than 40 public and private departments, agencies and organizations.

VDEM reorganized the Preparedness, Training and Exercise Division to create the Office of Training and Exercises to focus on the Commonwealth's training needs and the Preparedness Division to focus on state and local planning efforts.

Search and Rescue: The VDEM SAR program responded to 104 aircraft-related incidents and non-distress emergency beacons and 82 lost or missing person incidents. The SAR program trained 735 first responders in 2007. Virginia SAR provided Alzheimer's Intervention Training to public safety personnel in South Carolina and Florida. (Numbers will be finalized in March.)

Technological Hazards: VDEM Hazmat officers received 2,072 notifications of chemical releases in 2007. Hazardous Materials Officers responded to 106 of these incidents, of which 35 were significant enough to call in Regional Hazardous Materials Response Teams. Chemical spills or petroleum releases made up the majority of the calls, with a small percentage consisting of clandestine drug labs. In addition, staff conducted 97 classes throughout the Commonwealth and trained more than 3,775 first responders.

Virginia Emergency Operations Center: The VEOC handled 1,407 emergency notifications to local government and 634 medical evacuation missions for 2007, including requests for Virginia State Police Medflight and requests for private helicopter corporations. The VEOC hosted several major exercises for hurricane and radiological emergency events. The VEOC has had more than 8,300 visitors since moving into its new state-of-the-art facility in 2006.

State of emergency

Gov. Tim Kaine declared a state of emergency on Feb. 10 in response to wildfires spread by high winds. The fires burned more than 10,000 acres in 61 localities. The governor authorized the activation of Virginia National Guard personnel and equipment to assist with fighting the wildfires. The Virginia Department of Forestry coordinated firefighting response efforts. In addition to spreading fires, high winds knocked down trees and power lines, causing widespread power outages. The State Corporation Commission reported more than 100,000 power outages during the period of highest winds. VDEM coordinated the response to local requests for assistance. Current news releases and situation reports are available at http://www.vaemergency.com.

New FEMA program supports regional exercises

FEMA's National Exercise Division and the FEMA Regional Offices have started the Regional Exercise Support Program, formerly the NED Direct Support Exercise Program. The new program is a shift from a state-focused approach to a regional approach, organized by the FEMA Regions, meaning that Virginia will participate in more exercises at the regional level. The primary goals of the Regional Exercise Support Program are to support regionally coordinated exercises that address national security priorities.

State Administrative Agencies will determine their exercise support priorities and submit one application for each desired exercise (local jurisdictions and Urban Areas Security Initiative areas are required to submit applications to their respective SAA). FEMA will give priority to those exercise initiatives that fulfill National Exercise Program requirements.

Approved initiatives will have access to RESP funding and exercise support teams, through all phases of design, development, conduct and evaluation of preparedness exercises. At this time, the Regional Exercise Support Program will provide support for one discussion-based exercise (i.e., seminar, workshop or tabletop) and five operations-based (i.e. drills, functional exercises, full scale exercises) exercises within each of the 10 FEMA Regions

A Regional Exercise Support Program guide is available online at https://hseep.dhs.gov/pages/1001_HSEEP7.aspx.

Severe repetitive loss guidance and training

FEMA is offering $80 million through the FY08 Severe Repetitive Loss Pilot Program. The SRL program provides funding to reduce or eliminate the long-term risk of flood damage to severe repetitive loss residential structures insured under the National Flood Insurance Program. This program is available to fewer than 100 properties in 30 Virginia localities on FEMA's SRL list. Eligible projects include:

- Acquisition and relocation of at-risk structures and conversion of the property to open space
- Elevation of existing structures to at least the Base Flood Elevation or an Advisory Base Flood Elevation or higher. For the SRL program only, mitigation reconstruction is permitted only when traditional elevation cannot be implemented
- Minor physical localized flood reduction projects
- Dry floodproofing (historic properties only)

Grant guidance and application deadlines are available at http://www.fema.gov/library/viewRecord.do?id=3121.

VDEM will host a class about the program taught by FEMA on Feb. 20 at the Trade Court Facility. For additional information or to register, contact Hazard Mitigation Project Specialist Matthew Wall at (804) 897-6500, ext. 6541 or at Matthew.Wall@vdem.virginia.gov.

Homeland Security Grant Program guidance

The Department of Homeland Security has released FY08 guidance for 14 programs that comprise the Homeland Security Grant Program. DHS will distribute more than $3 billion through these programs to help territories, urban areas and transportation authorities bolster national preparedness capabilities and protect critical infrastructure.

- Homeland Security Grant Program: $1.69 billion
  - State Homeland Security Program: $862.9 million
  - Urban Areas Security Initiative: $781.6 million
  - Metropolitan Medical Response System: $39.8 million
  - Citizen Corps Program: $14.5 million
- Infrastructure Protection Program: $852.4 million
- Emergency Management Performance Grants: $291.4 million
- REAL ID Systems Integration and Data Verification Grant Program: $48.5 million
- Urban Areas Security Initiative Nonprofit Security Grant Program: $15 million

VDEM serves as the State Administrative Agency for these grants and will work with the Office of Commonwealth Preparedness to host grant stakeholder meetings with each of the seven Regional Preparedness Advisory Groups.

For more information about the grants, visit the Virginia Office of Commonwealth Preparedness Web site at http://www.commonwealthpreparedness.virginia.gov/initiatives/dhs_grants08.cfm.

WebEOC training for local governments

Due to large demand, VDEM has scheduled two additional training sessions for this class. WebEOC is a web-based crisis management information system used by the Commonwealth to provide real-time situational information and track requests for state assistance. The class offers an introduction to WebEOC, how to submit a local request for assistance and how to access situation reports, initial damages assessments and shelter information. VDEM continues to refine WebEOC functionality, and previous WebEOC training participants would benefit from attending this session. WebEOC will eventually replace Online EOC as the reporting channel between localities and the Virginia Emergency Operations Center. Training will be:

- March 4 in Roanoke
  Virginia Western Community College (Webber Hall, room 311)
  9 a.m. to noon
- March 5 in Lynchburg
  Central Virginia Criminal Justice Academy
  1 - 4 p.m.

There is also space available at the Feb. 28 and March 27 sessions scheduled at the VEOC in Chesterfield County. To register for one of these sessions, please e-mail Sue Ann Curran at SueAnn.Curran@vdem.virginia.gov specifying which session you would like to attend along with your name, title, locality, phone number and e-mail address.

Danville Campus CERT assists in real-world event

The Danville Community College Campus CERT assisted first responders during an incident on Oct. 11 that involved the report of an alleged gunman on campus. DCC CERT members made contact with the city of Danville's emergency operations center to ensure they were informed of the emergency; directed emergency responders onto campus; helped to lock down all seven campus buildings; performed a room-to-room search in each building; and spread the message about the lock down on campus. The team participated in an evaluation of their efforts and the college's response.

Ironically, just two days prior to this event, DCC CERT had designed and submitted a tabletop exercise that involved a gunman on campus. The first DCC Campus CERT class graduated in June 2007; the second graduated in January.

Lessons Learned: Fairfax Connector Bus Barricade

On Oct. 17, 2007, a gunman boarded a Fairfax Connector bus in the Hybla Valley area of Northern Virginia, which resulted in a more than three-hour standoff with law enforcement. Fairfax Connector, Fairfax County Police and the Fairfax Office of Emergency Management will review the training and interagency cooperation within the Incident Command System that led to the successful resolution for this event.

Speakers will include Fairfax County Police Captain JD Call, commander of the Special Operation Division, and Lieutenant Butch Gamble, assistant commander of the Traffic Division; and bus operator Feger Powell.

The free session will be Feb. 19, 1 – 4 p.m. at the Tuckahoe Area Library. Register by Feb. 15 at the Virginia Department of Rail and Public Transportation's Web site training section at http://www.drpt.virginia.gov/events/otc. For more information contact Amy Ettinger at (804) 786-1056 or Amy.Ettinger@drpt.virginia.gov.

Emergency Management grant opportunity for schools

The Readiness and Emergency Management for Schools discretionary grant program is offering $24 million to local education agencies to improve and strengthen their emergency management plans. School districts must commit to developing written plans that:

- Include the participation of law enforcement, public safety, public health, mental health and the head of the applicant's local government
- Coordinate with state Homeland Security plans
- Support the implementation of the National Incident Management System
- Prepare schools for a possible infectious disease outbreak, such as influenza pandemic
- Consider the communication, transportation and medical needs of individuals with disabilities within the school district.

Funds can be used to train school personnel and students in emergency management; communicate emergency management policies and reunification procedures to parents and guardians; coordinate with local emergency responders, including fire and police; purchase equipment; and coordinate with groups and organizations responsible for recovery issues, such as health and mental health agencies.

Last year, five Virginia public school districts shared more than $777,000 in grant awards through this program. All local education agencies are eligible to apply. Grant guidance and applications are available at http://www.grants.gov.

Long-Term Recovery Task Forces

The Department of Housing and Community Development organizes Long-Term Recovery Task Force volunteers to help communities recover from disasters, both large and small. These task forces work within their communities to develop creative ways to fulfill needs that insurance and federal aid do not cover. Emergency managers, local governments and volunteer organizations are encouraged to form an LTRTF before disaster strikes. Contact Local Disaster Recovery Task Forces State Coordinator Selby Jacobs at SelbyCJ@aol.com for more information.

Subscribe to EM Update **View EM Update Archives**

EM Update is the best way to communicate best practices and to get a heads up on issues that might affect you. Articles include case studies, cost/resource-saving local programs, examples of partnerships and regional cooperation and recognition of emergency managers who receive awards and honors in the field.

Please don't hesitate to contact the editor whenever you have a project that might benefit localities or want to highlight an important issue concerning Virginia's emergency response community. Contact Jolie Shank at (804) 897-6510 or by e-mail at pio@vdem.virginia.gov.

Produced by the Virginia Department of Emergency Management
10501 Trade Court, Richmond, Virginia 23236

Va. Scores High Marks for Emergency Preparedness

Feb 20, 2008, News Report

Governor Timothy M. Kaine today announced that Virginia scored high marks from the U.S. Centers for Disease Control and Prevention for the state's ability to manage public health emergencies.

Virginia scored 97 out of a possible 100 for its readiness to quickly distribute lifesaving medicines and medical supplies from the Strategic National Stockpile to the site of a natural or man-made disaster anywhere in the state.

"This score is evidence of our hard work and commitment to expanding our capacity to protect public health in the wake of a terrorist attack, pandemic flu, or other public health emergency," Governor Kaine said.

Virginia's goal is to redistribute the medicines and supplies received from the Strategic National Stockpile to local communities within 12 hours. The types of medicines included in community-bound packages include antibiotics, chemical antidotes, intravenous supplies and airway management supplies.

Virginia also scored high on measures related to disease detection and investigation as well as the ability of the public health laboratory to rapidly identify biological and chemical agents. Virginia is able to mount a multi-jurisdictional response with hospitals and local, state and federal emergency management organizations and conducts drills to measure emergency communications and response.

In December, 2007, the Virginia Department of Health scored a perfect 10 on its efforts to prepare the state to deal with major health emergencies from the Trust for American's Health. States were scored on 10 indicators that included ability to use the national stockpile, liability protection for volunteers and emergency preparedness drills.

For more information on Virginia's readiness to deal with emergencies visit the Virginia Department of Health's Web site at www.vdh.virginia.gov.

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APRIL 8, 2005

UASI Funding Process Defines Needs of National Capital Region

Allocation of Fiscal Year '05 UASI Funding Announced by NCR

Local and state officials in the National Capital Region (NCR), representing the District of Columbia's Mayor Anthony A. Williams, Maryland Governor Robert L. Ehrlich, Jr. and Virginia Governor Mark R. Warner, today announced that fiscal year 2005 Urban Area Security Initiative (UASI) funding levels have been approved. The $77.5 million in UASI grants from the U.S. Department of Homeland Security will be used for regional initiatives to prepare and secure the National Capital Region.

The NCR is unique since it is comprised of two states - Maryland and Virginia - as well as the District of Columbia. This complex regional structure, in the area that is home to the nation's capitol with the associated elevated risks, requires an equally complex system to determine how to best and most equitably allocate scarce resources such as UASI funds.

In a timely manner, a careful allocation of funds was done to meet demonstrated needs in four core areas - planning, equipment, training and exercise - to assist the NCR in building an enhanced and sustainable capacity to prevent, respond to, and recover from threats or acts of terrorism. These funds will provide substantive improvements in this region by developing regional capabilities to improve transportation systems, provide mass casualty support units, train the Citizen Corps and Medical Reserve Corps, provide for hospital surge capacity and other crucial projects with measurable outcomes that will make the NCR safer.

In the NCR, examples of UASI funded projects include the recently announced citizen education campaign to increase

personal preparedness of individuals in the National Capital Region; the development of a clearinghouse for training and coordination of regional emergency exercises; the establishment of two caches of 800 MHz radios to provide greater interoperability in the NCR; provision of disaster education for grades K-12; and additional protective gear for all fire and emergency responders in the NCR.

[Whereupon, at 12:30 p.m., the committee was adjourned.]
[Additional information submitted for the hearing record follows:]

UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
MAJORITY STAFF
MAY 2008

HOSPITAL EMERGENCY SURGE CAPACITY: NOT READY FOR THE "PREDICTABLE SURPRISE"

PREPARED FOR
CHAIRMAN HENRY A. WAXMAN

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EXECUTIVE SUMMARY

On March 11, 2004, on the eve of a major election in Spain, an attack on commuter trains in Madrid killed 177 instantly and injured more than 2,000. Nearly one thousand patients were transported to 15 hospitals. In less than three hours, 270 patients arrived at a single hospital in Madrid.

The Centers on Disease Control and Prevention says that a terrorist bombing in the United States like the one in Madrid is a "predictable surprise." According to the CDC, the 2004 Madrid bombing is an appropriate standard for assessing whether the emergency care system in the United States is prepared to respond to a terrorist attack.

At the request of Chairman Henry A. Waxman, the majority staff of the Committee conducted a survey of Level I trauma centers in seven major U.S. cities to assess whether they have the capacity to respond to the level of casualties experienced in the Madrid attack. The survey included five of the cities considered at highest risk of a terrorist strike: New York City, Los Angeles, Washington, D.C., Chicago, and Houston. It also included Denver and Minneapolis, where the 2008 Democratic and Republican conventions will be held.

The Level I trauma centers surveyed are not the only providers of emergency care in the seven cities, but they are the hospitals that can provide the highest levels of injury care and would be the preferred destinations for casualties in the event of a terrorist attack involving conventional explosives. Severely injured patients treated at Level I trauma centers have a significantly lower risk of death than patients treated at hospitals that are not trauma centers.

The survey was conducted on Tuesday, March 25, 2008, at 4:30 p.m. local time in each of the seven cities. The survey was designed to determine the real-time capacity of the emergency rooms at the Level I trauma centers to absorb a sudden influx from a mass casualty event. Thirty-four of the 41 Level I trauma centers in these cities participated in the survey.

The results of the survey show that none of the hospitals surveyed in the seven cities had sufficient emergency care capacity to respond to an attack generating the number of casualties that occurred in Madrid. The Level I trauma centers surveyed had no room in their emergency rooms to treat a sudden influx of victims. They had virtually no free intensive care unit beds within their hospital complex. And they did not have enough regular inpatient beds to handle the less severely injured victims. The shortage of capacity was particularly acute in Los Angeles and Washington, D.C.

The survey found that on March 25, 2008, at 4:30 p.m. local time, emergency room crowding was severe in the hospitals surveyed:

- **More than half of the emergency rooms in the Level I trauma centers surveyed were operating above capacity.** When an emergency room reaches "capacity," new patients can be accommodated only in overflow spaces, such as hallways, waiting rooms, or administrative offices. Of the 34 Level I trauma centers surveyed, 20 (59%) were operating over capacity, meaning they had no available treatment space in the emergency room to accommodate new patients. The average emergency room was operating at 115% of capacity in the Level I trauma centers in the seven cities.

- **The total number of available emergency room treatment spaces in each of the seven cities was less than the number treated at a single Madrid hospital.** After the Madrid attack, 966 victims were transported to 15 hospitals, and 270 victims arrived at a single hospital for emergency care. Not one of the seven cities had sufficient treatment spaces in emergency rooms of their Level I trauma centers to handle the volume of victims seen at a single Madrid hospital. Across all hospitals surveyed in New York City, the city with the most available emergency room space, there were only 56 emergency room treatment spaces available in the Level I trauma centers. All the other cities had even less available emergency room treatment space in their Level I trauma centers.

- **In Los Angeles, three of the five hospitals surveyed were on diversion.** Because Level I trauma centers represent such a vital resource for trauma patients, these hospitals are not supposed to divert ambulances unless they are dangerously overcrowded. On the afternoon of the survey, however, three of the five Level I trauma centers in Los Angeles were on diversion. Together, these five Level I trauma centers had only six vacant treatment spaces available in their emergency rooms at the time of the survey.

- **In Washington, D.C., there were no available spaces in the emergency rooms of the two Level I trauma centers surveyed.** Two of the three Level I trauma centers in the nation's capital responded to the survey: the Washington Hospital Center and the George Washington University Medical Center. The emergency rooms in both hospitals were severely overcrowded at the time of the survey, with no available treatment spaces. The emergency room at the Washington Hospital Center was operating at 286% of capacity, making it the single most overcrowded hospital surveyed.

Surge capacity depends on more than sufficient space in the emergency room. A hospital must also be able to provide sufficient critical care resources, such as space in intensive care units, and inpatient beds. If these beds are not available, patients who require hospitalization are frequently "boarded" in the emergency room until they can be moved to an intensive care unit or inpatient bed. On the day of the survey, there were such severe shortages of critical care and inpatient beds that many of the hospitals we surveyed were already "boarding" admitted patients in their emergency room. The survey found:

- **None of the Level I trauma centers surveyed had enough critical care capacity available for seriously injured casualties from a Madrid event.** After the Madrid attack, 29 patients arrived at one hospital in critical condition. None of 34 Level I trauma centers surveyed had sufficient critical care capacity to handle this volume of severely injured victims. On average, the trauma centers surveyed had only five intensive care unit beds available. Six hospitals (18%) had no available intensive care unit beds.

- **None of the Level I trauma centers surveyed had a sufficient number of regular inpatient beds available to absorb the casualties from a Madrid event.** In Madrid, a single hospital received 89 casualties that required admission to an inpatient bed. No Level I trauma center surveyed had sufficient available beds to accommodate a surge of this size. On average, the Level I trauma centers had only 24 beds available.

After conducting the "snapshot" survey on March 25 at 4:30 p.m., the Committee staff sent follow-up questionnaires to the hospitals surveyed. Twenty-three of the hospitals responded to the questionnaire. Their responses indicate that the level of emergency care they can provide is likely to be further compromised by three new Medicaid regulations, the first of which takes effect on May 26, 2008. According to these hospitals, the new Medicaid regulations will reduce federal payments to their facilities by $623 million per year. If the states choose to withdraw their matching funds, the hospitals could face a reduction of about $1.2 billion. The hospitals told the Committee that these funding cuts will force them "to significantly reduce services" in the future and that "loss of resources of this magnitude inevitably will lead to curtailing of critical health care safety net services such as emergency, trauma, burn, HIV/AIDS, neonatology, asthma care, diabetes care, and many others."

I. INTRODUCTION

Conventional explosives are regarded by many experts as the most likely type of terrorist attack in the United States. The Director of National Intelligence testified before the Senate Select Committee on Intelligence on February 5, 2008, that "we judge use of a conventional explosive to be the most probable al-Qa'ida attack scenario because the group is proficient with conventional small arms and improvised explosive devices and is innovative in creating capabilities and overcoming security obstacles."[1] According to the Centers on Disease Control and Prevention, "a terrorist bombing in the United States would be a 'predictable surprise.'"[2]

Emergency rooms and trauma centers are a key resource in responding to such a bomb attack. The CDC estimates that "federal resources should not be expected to arrive sooner than 72 hours from the time of the explosion."[3] This is too long for many critically injured victims. Experts call the first hour following a major trauma the "golden hour" because of the importance of immediate and definitive care. Only local emergency and trauma care capacity will be available to treat the mass casualties in the early hours following a conventional explosives attack.

In a 2007 report, the CDC used the 2004 Madrid bombing as a standard for assessing mass casualty preparedness following an explosive attack.[4] The Madrid bombing was selected because it generated the type of surge of wounded victims expected after a terrorist attack. In the Madrid attack, which occurred on March 11, 2004, ten terrorist explosions occurred almost simultaneously on commuter trains in Madrid, killing 177 people instantly and injuring more than 2,000. That day, 966 patients were taken to 15 hospitals. Within just 2.5 hours of the explosions, more than 270 patients arrived at Gregorio Maranon University General Hospital (GMUGH), the closest facility and the largest public hospital in Madrid.[5] Among the casualties arriving at this single hospital, 89 required hospital admission and 29 required critical care.[6]

At the request of Chairman Henry A. Waxman, this report assesses whether the emergency care facilities at major hospitals in large U.S. cities would be able to respond to a Madrid event. This is the first report to measure our nation's hospital emergency surge capacity using Madrid as a standard.

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[1] Senate Select Committee on Intelligence, Testimony of J. Michael McConnell, Director of National Intelligence, *Annual Threat Assessment* (Feb. 5, 2008).

[2] CDC, *At a Moment's Notice: Surge Capacity for Terrorist Bombings*" (Apr. 2007).

[3] *Id.*

[4] *Id.*

[5] *Id.* A total of 312 casualties were eventually treated at GMUGH, but 272 casualties arrived immediately following the attack, between 8 a.m. and 10:30 a.m.

[6] Gutierrez de Ceballos, et al., *11 March 2004: The terrorist bomb explosions in Madrid, Spain — an analysis of the logistics, injuries sustained and clinical management of casualties treated at the closest hospital*, Critical Care (Feb. 2005).

II. METHODOLOGY

To evaluate the preparedness of the nation's hospital emergency care capacity, the majority staff of the Committee conducted a survey of the Level I trauma centers in seven major American cities. The survey includes five cities that are at highest risk of a terrorist strike according to the Department of Homeland Security: New York City, Los Angeles, Washington, D.C., Chicago, and Houston.[7] The other two cities in the survey are Denver and Minneapolis, the cities in which the 2008 Democratic and Republican conventions will be held.

Hospitals with Level I trauma centers were selected because they serve as regional referral centers for persons with the most serious injuries. To be designated as a Level I trauma center, a hospital must have "immediate availability of trauma surgeons, anesthesiologists, physician specialists, nurses, and resuscitation equipment."[8] Because Level I trauma centers have a greater ability to treat critical injuries, the most severely injured victims of mass casualty events are often preferentially routed to these centers. According to a study funded by the CDC, severely injured patients treated at hospitals with Level I trauma centers have a 25% lower risk of death than patients treated at a nontrauma center.[9] In the seven cities surveyed, there are 41 Level I trauma centers. The survey excluded Level I trauma centers that treat pediatric patients only.[10]

To assess the preparedness of the Level I trauma centers in these seven cities for a mass casualty event, the staff administered a snapshot survey to determine the capacity of the facilities at a single point in time. The snapshot survey was modified from a protocol used to generate a 2003 Government Accountability Office report on emergency room crowding.[11] In designing the survey, the staff received comments from GAO and multiple professional organizations and experts. The survey was then pilot tested with three separate emergency department physicians. The survey instrument is reproduced in Appendix H.

In conducting the survey, the Committee staff collected point-in-time data by telephone at 4:30 p.m. local time on Tuesday, March 25, 2008. The survey was conducted by a physician on Committee staff with the assistance of two fourth-year medical student fellows.

The Committee also sent a follow-up questionnaire to the administrators of each of the hospitals surveyed. The questionnaire was distributed with the assistance of the National

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[7] Department of Homeland Security, Tier I Urban Area Security Initiative Jurisdictions (online at www.dhs.gov/xlibrary/assets/grants-2007-program-overview-010507.pdf).

[8] MacKenzie EJ, et al. National Inventory of Hospital Trauma Centers. *JAMA*. 2003; 289:1515-1522. Specific criteria for "Level I" hospitals vary by metropolitan area. For purposes of this report, all city-designated "Level I" or "regional" trauma centers are referred to as "Level I trauma centers."

[9] MacKenzie EJ, et al. A National Evaluation of the Effect of Trauma-Center Care on Mortality. *NEJM* 2006;354:366-378.

[10] Survey respondents were asked to limit capacity estimates to adult patients where possible.

[11] GAO, *Hospital Emergency Departments: Crowded Conditions Vary among Hospitals and Communities* (Mar. 2003).

Association of Public Hospitals, the Association of Academic Medical Centers, and the American Hospital Association. The questionnaire is reproduced in Appendix I.

III. FINDINGS

Of the 41 Level I trauma centers in the selected cities, 34 (83%) participated in the hospital snapshot survey, representing over a fifth of the total emergency care capacity across the seven cities.[12] The results from these hospitals show that none of the surveyed facilities had sufficient capacity to respond to a Madrid event. Even if the emergency care resources of the Level I trauma centers were pooled in each surveyed city, none of the seven cities had sufficient capacity to manage the number of casualties that sought care at a single hospital emergency room in Madrid in the first few hours following the terrorist bombings there.

A. Emergency Room Capacity as Compared to Madrid

At the time of the survey, 20 of the 34 emergency rooms surveyed (59%) were functioning at or over capacity. Across all 34 Level I trauma centers, the emergency rooms in the survey were operating at 115% of capacity. See Table 1. This means that at the time of the survey, 15% of the patients were being treated in overflow spaces such as hallways, waiting rooms, or administrative offices. Patients waiting in an emergency room to see a health care provider are not included in these estimates.[13]

According to one facility, overcrowding has been such a severe problem that when mentally disabled adults were recently evacuated from a nearby care center, they had to be treated in the bus that brought them to the hospital because there were no available treatment spaces inside the emergency room.

In Madrid, 270 of the 2,000 total casualties arrived at the emergency room of a single hospital, GMUGH, in the first 2.5 hours after the attack. In the emergency rooms of the Level I trauma centers surveyed, there would not be enough capacity to accommodate a similar surge of injured patients unless other seriously ill or injured patients were displaced. Nearly all of these casualties would have to be treated in overflow spaces such as hallways and offices, assuming these overflow spaces were not already in use.

Not a single Level I trauma center emergency room had enough available capacity to accommodate more than 10% of the 270 casualties that arrived at a single emergency room after the Madrid attack. In the Level I trauma centers surveyed in Washington, D.C., there were no available treatment spaces; in the Level I trauma centers in Los

[12] According to data from the American Hospital Association's 2006 Annual Survey of Hospitals, there were a total of 10,051,161 emergency room visits across all of the hospitals in the regions included in the survey; of these, 2,138,092 (21%) occurred in the 34 hospitals responding to our survey.

[13] According to survey respondents, the number of people waiting to see a health care provider represent an additional 45% of emergency room capacity across the hospitals surveyed.

Angeles, there were only six available spaces. In New York City, the city with the most available treatment spaces, there were no available spaces in 10 of the 16 Level I trauma centers surveyed. There were 56 available spaces in remaining 6 Level I trauma centers. See Appendix A.

On the day of the Madrid bombing, 966 casualties were taken to hospitals across the city, more than eight times the total number of standard treatment spaces available in all 34 surveyed Level I trauma centers in seven cities. The survey is not a comprehensive examination of the surge capacity in each of the seven cities, but a sampling of the institutions most likely to play a major role in the response to any terrorist attack.

Table 1:
Emergency room capacity at Level I trauma centers, by city
(4:30 p.m., Tuesday, March 25, 2008)

City	Patients Being Treated	Treatment Spaces (Capacity)	% of Capacity Being Treated in ER	Available Treatment Spaces	Available Treatment Spaces, as % of Surge at One Madrid Hospital (270 Casualties)
New York City	943	829	114%	56	21%
Los Angeles	286	246	116%	6	2%
Washington, D.C.	135	63	214%	None	0%
Chicago	203	152	134%	8	3%
Houston	123	154	80%	32	12%
Denver	81	88	92%	8	3%
Minneapolis	52	57	91%	5	2%

Overcrowding was particularly severe in Los Angeles and Washington, D.C. In Los Angeles, three of the five Level I trauma centers were "on diversion" at the time of the survey. This means they were too full to accept new patients and were directing ambulances to alternative sites. Because Level I trauma centers represent such an important resource for patients with serious injuries, these hospitals have a high threshold for going "on diversion." Diversions can also have a ripple effect, as patients redirected from one hospital increase the crowding at nearby institutions. In total, there were just six available emergency room treatment spaces in the five Level I trauma centers in Los Angeles.

In Washington, D.C., there were no available spaces in the emergency rooms of the Level I trauma centers surveyed. Two of the three Level I trauma centers in our nation's capital responded to the survey: the Washington Hospital Center and the George Washington University Medical Center.[14] On the date of the survey, the emergency rooms of both

[14] The only Level I trauma center in Washington, D.C. that did not respond is Howard University Hospital. According to the regional EMS authorities in Washington, D.C., Howard University Hospital was on diversion on March 25, 2008, at 4:30 p.m.

hospitals were severely overcrowded, with no available treatment spaces in either emergency room. The emergency room at the Washington Hospital Center was operating at 286% of capacity, making it the single most overcrowded hospital the Committee surveyed. See Appendix A.

As part of the survey, the respondents, primarily physicians in the emergency department, were asked about the impact on health of overcrowding and delays in emergency care treatment. Over 44% of those surveyed reported that the respondent personally knew of a patient who had been harmed by the delays in medical intervention resulting from emergency room overcrowding. One respondent reported that because of a recurring inability to see patients in a timely fashion, the hospital set up a medication dispensing machine in the waiting room in an effort to control pain and nausea in patients facing long waits to see a health care provider.

B. Inpatient Capacity as Compared to Madrid

Surge capacity depends on more than just the emergency room. It also requires that a hospital have sufficient inpatient resources, including accessible intensive care units (ICUs).

When a hospital is full, severely ill and injured emergency room patients cannot be moved out of the emergency room into a hospital bed. This bottleneck creates "boarders": patients admitted to the hospital who remain in the emergency room because no hospital bed is available. Because these patients require space, equipment, and the ongoing attention of the emergency room staff, they limit the resources available to incoming emergency room patients and exacerbate crowding.

On the day of the survey, boarders occupied a quarter of the total capacity (25%) in the emergency rooms of the 34 trauma centers surveyed. Eight hospitals reported that some of their boarders had been waiting for an inpatient bed for 24 hours or more. At Winthrop University Hospital in New York City, one boarder had been waiting more than four days for an inpatient bed. See Appendix D.

Boarding was particularly problematic in New York City and Washington, D.C. Six of the eight hospitals with boarders waiting 24 hours or more for an inpatient bed were in New York City. In Washington, D.C., boarders occupied 60% of the total emergency room capacity in the two surveyed Level I trauma centers.

On the day of the Madrid train bombings, of the 270 patients who came to the emergency room of a single hospital, 89 patients required admission to an inpatient hospital bed. None of the 34 Level I trauma centers surveyed had 89 inpatient beds available. On average, the hospitals surveyed had approximately 20 inpatient beds available. See Appendix B. Four of the seven cities (Washington, D.C., Houston, Denver, and Minneapolis) did not have enough inpatient beds available across the Level I trauma centers surveyed to accommodate the 89 patients who required admission to a single hospital after the Madrid bombing.

Critical care capacity is a crucial resource in addressing a mass casualty event because the most severely injured patients require treatment in an intensive care unit to survive. The Madrid hospital that received the largest share of victims had 29 patients who required critical care following the bombings.

At the time of the Committee's survey, the Level I trauma centers had on average five intensive care unit beds available. Five hospitals (18%) had no available intensive care unit beds. No Level I trauma center included in the survey had the intensive care unit capacity to accommodate the 29 patients who required critical care at one Madrid hospital after the train bombings. See Appendix C. Five cities in the Committee's survey (Los Angeles, Washington, D.C., Houston, Denver, and Minneapolis) had less than 29 critical care beds available across all participating trauma centers. See Table 2.

Table 2:
Intensive Care Unit (ICU) surge capacity at Level I trauma centers, by city (4:30p.m., Tuesday, March 25, 2008)

City	Intensive Care Unit Beds (Capacity)	Available Intensive Care Unit Beds	Available Intensive Care Unit Beds as % of Surge at One Madrid Hospital (29 Casualties)
New York City	797	79	272%
Los Angeles	371	9	31%
Washington, D.C.	160	12	41%
Chicago	217	37	128%
Houston	263	11	38%
Denver	146	9	31%
Minneapolis	48	3	10%

C. Creating Additional Capacity

In the event of a terrorist attack, hospitals will create some additional capacity by rapidly discharging ambulatory patients and transferring others wherever possible. At the hospital in Madrid that received 270 victims after the bombing attacks, 123 patients were sent home from the emergency room and 161 hospitalized patients were discharged home from inpatient beds in under two hours, about 9% of the 1,800 beds at that hospital.[15]

It is unlikely that similar resources can be "freed up" in a typical U.S. Level I trauma center. In its report, the CDC noted that excess capacity is difficult to create in this country due to the fact that "the U.S. health care system has systematically and

[15] Gutierrez de Ceballos, et al., *11 March 2004: The terrorist bomb explosions in Madrid, Spain — an analysis of the logistics, injuries sustained and clinical management of casualties treated at the closest hospital*, Critical Care (Feb. 2005).

deliberately eliminated capacity because unused capacity is an additional expense."[16] The Institute of Medicine's June 2006 report on the future of emergency care states:

> In many cities, the hospitals and trauma centers have problems dealing with a multiple car highway crash, much less a major mass casualty event. With many hospitals operating at or near capacity, most hospitals do not have the capacity to handle the volume of patients likely to result from a large-scale disaster. In emergencies, there are a number of things that hospitals can do to free up capacity and extend their resources. But there are serious physical limits to such expansions.[17]

Moreover, even if the Level I trauma centers could discharge and transfer as many patients as occurred at the hospital in Madrid, the trauma centers would still lack sufficient space to accommodate the surge of victims that received emergency care at the Madrid hospital.

D. Conditions as Compared to Other Days

The survey was conducted at one specific time, 4:30 p.m., on a single weekday, Tuesday, March 25, 2008. To assess whether the hospital conditions at the time of the survey were representative, the Committee staff obtained data for the seven cities on hospital diversions. This data is maintained by the providers of ambulance and related emergency medical services (EMS), who are notified whenever a hospital in a city goes on diversion so that they can divert patients elsewhere.

The diversion data indicates that the conditions at the time of the survey were not unusual. For most of the cities, the overall rate of diversion for the month prior to the survey was comparable to the rate of diversions on March 25. In some instances, conditions appeared less crowded on the date of the survey than other days. The data from the Los Angeles EMS system showed that Los Angeles hospitals were on diversion an average of 28% of the time during the prior month, a higher rate of diversion than the 21% rate on March 25. Only two cities (Washington, D.C. and Minneapolis) had significantly more diversions on March 25 than over the previous month. See Appendix E.

E. The Impact of Medicaid Regulations

In a follow-up questionnaire, the hospitals were asked what impact three pending changes to Medicaid regulations would have on the ability of the hospitals to provide emergency response. Twenty-three of the hospitals responded to the questionnaire. They indicated that the regulations would result in large financial losses for these critical institutions and result in further strain in emergency room care. See Appendix I.

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[16] CDC, *At a Moment's Notice: Surge Capacity for Terrorist Bombings"* (Apr. 2007).

[17] Institute of Medicine. *Hospital-Based Emergency Care: At the Breaking Point*. National Academies Press, Washington, D.C. (2006).

During 2007, the Centers for Medicare & Medicaid Services (CMS) proposed seven regulations that would make major, wide-ranging changes in federal Medicaid policy.[18] Three of these regulations would significantly reduce federal Medicaid funding for public and teaching hospitals that are major providers of emergency care in many communities. More specifically, one would limit Medicaid payments to public providers;[19] another would bar Medicaid payment for graduate medical education;[20] and the third would limit the scope of outpatient hospital services for which Medicaid pays.[21]

Across all seven cities, the Level I trauma centers estimated a potential annual loss between $623 million and $654 million in federal Medicaid funds from the three regulations. See Table 3. Nationally, federal Medicaid payments represent between 50% and 75% of total Medicaid payments to hospitals, depending on the state. The remaining funding is contributed by individual states. If the states also elect to withdraw their own funding because it would no longer be matched, the Level I trauma centers could lose a total of about $1.2 billion per year.[22]

Table 3:
Estimated annual loss of federal Medicaid funds to Level I trauma centers, by city (in millions)

City	Cost Limit Rule	GME Rule	Outpatient Hospital Rule	Total Funding
New York City	116	234	35	**384**
Los Angeles	85	18	2	**104**
Chicago	25 - 35	4	1	**30-40**
Houston	70-81	4	0.2	**74-85**
Denver	30 - 40	0.4	NS	**30 - 40**
Total Nationwide*	**326-357**	**260**	**38**	**623-654**

*Totals may not add up by column due to rounding.

[18] For further information, see Committee on Oversight and Government Reform, Majority Staff, *The Administration's Medicaid Regulations: State-by-State Impacts* (March 2008).

[19] Centers for Medicare & Medicaid Services, Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of the Federal-State Financial Partnership, 72 Fed. Reg. 29748 (May 29, 2007)(final rule with comment period). This regulation limits Medicaid payments to public hospitals for inpatient services to the cost of treating Medicaid patients, thereby denying these facilities assistance in financing the costs of treating uninsured patients admitted through the emergency room

[20] Centers for Medicare & Medicaid Services, *Medicaid Program; Graduate Medical Education*, 72 Fed. Reg. 28930 (May 23, 2007)(proposed rule). This regulation would prohibit federal Medicaid matching funds for payment for the costs of GME programs, through which residents are trained to become doctors by providing inpatient or outpatient hospital services to Medicaid and uninsured patients.

[21] Centers for Medicare & Medicaid Services, *Medicaid Program; Clarification of Outpatient Clinic and Hospital Facility Services Definition and Upper Payment Limit*, 72 Fed. Reg. 55158 (Sept. 28, 2007) (proposed rule). This regulation narrows the scope of outpatient hospital services for which federal Medicaid matching funds are available to those services for outpatient hospital services for which Medicare pays.

[22] Hospitals reported to the Committee the total funding at risk as a result of these regulations. The Committee staff used the applicable federal Medicaid matching rate to determine the amount of federal funds at risk.

The Level I trauma centers surveyed could lose on average about $27 million annually in federal Medicaid funds as a result of the regulations. This amount is approximately 5% of the hospitals' annual budget. If states choose to also reduce contributions, the loss could be nearly twice as great.

Some of the hospitals would face a particularly large impact. Ben Taub General Hospital in Houston estimated that $49 million to $61 million in federal dollars would be at risk as a result of these three regulations. In New York City, New York Presbyterian estimated that about $63 million in federal funds was at risk. Three hospitals (Jacobi Medical Center in New York City, Lincoln Medical and Mental Health Center in New York City, and John H. Stroger Hospital of Cook County in Chicago) estimate that the federal funds at risk account for over 10% of their annual budget. See Appendix F.

Some respondents offered comments regarding the impact of the regulations on emergency services. According to the John H. Stroger Hospital of Cook County in Chicago, "loss of resources of this magnitude inevitably will lead to curtailing of critical health care safety net services such as emergency, trauma, burn, HIV/AIDS, neonatology, asthma care, diabetes care, and many others." The USC Medical Center reported that "the impact of these regulations will undoubtedly result in reduced inpatient and outpatient services in Los Angeles County. Decreased access will result in further impacts to emergency rooms already overwhelmed by increasing patient volumes."

Others commented on the broad effects of the regulations. Denver Health responded that "the impact of these regulations, if implemented, will be to devastate the Colorado safety net system requiring Colorado's safety net hospitals to substantially decrease care to the uninsured." Ben Taub General Hospital in Houston said that, if the regulations go into effect, "the hospital district will have to significantly reduce services to the uninsured and indigent patients ... in order to bring the cost of services provided in line with funds available." Administrators from several hospitals with low projected fiscal impacts noted "significant indirect financial impact[s]" as reductions in funding to public hospitals "result in shifts in the indigent patient population to the other ... safety net hospitals." Additional comments are presented in Appendix G.

Appendix A: Emergency room capacity at Level I trauma centers, by hospital (4:30 p.m., Tuesday, March 25, 2008)

Hospital Name	Metro Area	Patients Being Treated	Treatment Spaces (Capacity)	% of Capacity Being Treated in ER	Available Treatment Spaces	Available Treatment Spaces, as % of Surge at One Madrid Hospital (270 Casualties)
Bellevue Hospital Center	NYC	71	34	209%	None	0%
Brookdale Hospital Medical Center	NYC	26	34	76%	8	3%
Elmhurst Hospital Center	NYC	64	56	114%	None	0%
Harlem Hospital Center	NYC	17	40	43%	23	9%
Jacobi Medical Center	NYC	60	48	125%	None	0%
Jamaica Hospital Medical Center	NYC	50	24	208%	None	0%
Kings County Hospital Center	NYC	47	67	70%	20	
Lincoln Medical and Mental Health Center	NYC	63	64	98%	1	0.4%
New York Presbyterian Hospital	NYC	110	103	107%	None	0%
St. Barnabas Hospital	NYC	49	52	94%	3	1%
St. Lukes Roosevelt Hospital	NYC	83	47	177%	None	0%
Staten Island University Hospital	NYC	49	30	163%	None	0%
Stony Brook University Hospital	NYC	68	64	106%	None	0%
St. Vincents Manhattan	NYC	62	47	132%	None	0%
Winthrop University Hospital	NYC	59	53	111%	None	0%
The University Hospital	NYC	65	66	98%	1	0.4%
Washington Hospital Center	DC	83	29	286%	None	0%
George Washington University Medical Center	DC	52	34	153%	None	0%

Appendix A: Emergency room capacity at Level I trauma centers, by hospital (4:30 p.m., Tuesday, March 25, 2008) (Continued)

Hospital Name	Metro Area	Patients Being Treated	Treatment Spaces (Capacity)	% of Capacity Being Treated in ER	Available Treatment Spaces	Available Treatment Spaces, as % of Surge at One Madrid Hospital (270 Casualties)
Advocate Illinois Masonic Hospital	Chicago	33	41	80%	8	3%
John H. Stroger Hospital of Cook County	Chicago	84	60	140%	None	0%
Mount Sinai Hospital and Medical Center	Chicago	38	23	165%	None	0%
Northwestern Memorial Hospital	Chicago	48	28	171%	None	0%
Ben Taub General Hospital	Houston	56	73	77%	17	6%
Memorial Hermann Hospital	Houston	38	37	103%	None	0%
University of Texas Medical Branch	Houston	29	44	66%	15	6%
Hennepin County Medical Center	Minneapolis	52	57	91%	5	2%
St. Anthony Central Hospital	Denver	19	18	106%	None	0%
Denver Health Medical Center	Denver	31	33	94%	2	0.7%
Swedish Medical Center	Denver	31	37	84%	6	2%
Cedars-Sinai Medical Center	LA	57	41	139%	None	0%
Harbor UCLA Medical Center/LAC	LA	60	61	98%	1	0.4%
USC Medical Center	LA	102	81	126%	None	0%
UCLA Medical Center	LA	37	28	132%	None	0%
UCI Medical Center	LA	30	35	86%	5	2%

Appendix B: Inpatient hospital bed capacity at Level I trauma centers, by hospital (4:30 p.m., Tuesday, March 25, 2008)

Hospital Name	Metro Area	Total Hospital Beds (Capacity)	Available Hospital Beds	Available Hospital Beds, as % of Surge at One Madrid Hospital (89 Casualties)
Bellevue Hospital Center	NYC	390	13	15%
Brookdale Hospital Medical Center	NYC	310	42	47%
Elmhurst Hospital Center	NYC	267	27	30%
Harlem Hospital Center	NYC	175	20	23%
Jacobi Medical Center	NYC	234	6	2%
Jamaica Hospital Medical Center	NYC	244	29	32%
Kings County Hospital Center	NYC	309	9	9%
Lincoln Medical and Mental Health Center	NYC	207	52	58%
New York Presbyterian Hospital	NYC	1404	70	79%
St. Barnabas Hospital	NYC	350	17	19%
St. Lukes Roosevelt Hospital	NYC	316	4	5%
Staten Island University Hospital	NYC	319	19	25%
Stony Brook University Hospital	NYC	380	30	34%
St. Vincents Manhattan	NYC	260	8	9%
Winthrop University Hospital	NYC	471	8	9%
The University Hospital	NYC	455	16	18%
Washington Hospital Center	DC	644	29	33%
George Washington University Medical Center	DC	302	18	20%
Advocate Illinois Masonic Hospital	Chicago	188	38	43%
John H. Stroger Hospital of Cook County	Chicago	298	19	21%
Mount Sinai Hospital and Medical Center	Chicago	172	3	3%
Northwestern Memorial Hospital	Chicago	504	58	65%
Ben Taub General Hospital	Houston	447	46	28%
Memorial Hermann Hospital	Houston	535	17	35%
University of Texas Medical Branch	Houston	555	4	10%
Hennepin County Medical Center	Minn.	231	29	33%
St. Anthony Central Hospital	Denver	215	22	3%
Denver Health Medical Center	Denver	257	2	17%
Swedish Medical Center	Denver	255	12	10%
Cedars-Sinai Medical Center	LA	588	26	7%
Harbor UCLA Medical Center/LAC	LA	367	48	24%
USC Medical Center	LA	520	26	31%
UCLA Medical Center	LA	321	42	7%
UCI Medical Center	LA	198	0	0%

Appendix C: Intensive Care Unit (ICU) capacity at Level I trauma centers, by hospital (4:30 p.m., Tuesday, March 25, 2008)

Hospital Name	Metro Area	Total ICU Beds (Capacity)	Available ICU Beds	Available ICU Beds, as % of Surge at One Madrid Hospital (29 Casualties)
Bellevue Hospital Center	NYC	56	5	17%
Brookdale Hospital Medical Center	NYC	30	8	28%
Elmhurst Hospital Center	NYC	29	3	10%
Harlem Hospital Center	NYC	16	2	7%
Jacobi Medical Center	NYC	44	2	7%
Jamaica Hospital Medical Center	NYC	24	3	10%
Kings County Hospital Center	NYC	40	5	17%
Lincoln Medical and Mental Health Center	NYC	30	7	24%
New York Presbyterian Hospital	NYC	208	16	55%
St. Barnabas Hospital	NYC	26	3	10%
St. Lukes Roosevelt Hospital	NYC	40	2	7%
Staten Island University Hospital	NYC	42	10	34%
Stony Brook University Hospital	NYC	54	7	24%
St. Vincents Manhattan	NYC	42	0	0%
Winthrop University Hospital	NYC	56	0	0%
The University Hospital	NYC	60	6	21%
Washington Hospital Center	DC	112	9	31%
George Washington University Medical Center	DC	48	3	10%
Advocate Illinois Masonic Hospital	Chicago	34	7	24%
John H. Stroger Hospital of Cook County	Chicago	70	8	28%
Mount Sinai Hospital and Medical Center	Chicago	21	1	3%
Northwestern Memorial Hospital	Chicago	92	21	72%
Ben Taub General Hospital	Houston	70	5	17%
Memorial Hermann Hospital	Houston	115	6	21%
University of Texas Medical Branch	Houston	78	0	0%
Hennepin County Medical Center	Minn.	48	3	10%
St. Anthony Central Hospital	Denver	60	6	21%
Denver Health Medical Center	Denver	44	2	7%
Swedish Medical Center	Denver	42	1	3%
Cedars-Sinai Medical Center	LA	144	2	7%
Harbor UCLA Medical Center/LAC	LA	42	6	21%
USC Medical Center	LA	72	0	0%
UCLA Medical Center	LA	68	1	3%
UCI Medical Center	LA	45	0	0%

Appendix D: Emergency room capacity being used to treat "boarders" at 4:30 p.m., March 25, 2008

Hospital Name	Metro Area	Boarders Being Treated	Treatment Spaces (Capacity)	% of Capacity Occupied by Boarders	Longest Waiting Time for a Boarder (in hours)
Bellevue Hospital Center	NYC	20	34	59%	16
Brookdale Hospital Medical Center	NYC	1	34	3%	1
Elmhurst Hospital Center	NYC	12	56	21%	12
Harlem Hospital Center	NYC	2	40	5%	9
Jacobi Medical Center	NYC	17	48	35%	20
Jamaica Hospital Medical Center	NYC	11	24	46%	5
Kings County Hospital Center	NYC	10	67	15%	19
Lincoln Medical and Mental Health Center	NYC	2	64	3%	2
New York Presbyterian Hospital	NYC	35	103	34%	28
St. Barnabas Hospital	NYC	6	52	12%	3
St. Lukes Roosevelt Hospital	NYC	19	47	40%	30
Staten Island University Hospital	NYC	31	30	103%	40
Stony Brook University Hospital	NYC	3	64	5%	9
St. Vincents Manhattan	NYC	17	47	36%	24
Winthrop University Hospital	NYC	39	53	74%	100
The University Hospital	NYC	13	66	20%	48
Washington Hospital Center	DC	30	29	103%	33
George Washington University Medical Center	DC	8	34	24%	5
Advocate Illinois Masonic Hospital	Chicago	5	41	12%	0
John H. Stroger Hospital of Cook County	Chicago	4	60	7%	1
Mount Sinai Hospital and Medical Center	Chicago	11	23	48%	15
Northwestern Memorial Hospital	Chicago	5	28	18%	1
Ben Taub General Hospital	Houston	6	73	8%	5
Memorial Hermann Hospital	Houston	5	37	14%	22
University of Texas Medical Branch	Houston	9	44	20%	11
Hennepin County Medical Center	Minneapolis	5	57	9%	7
St. Anthony Central Hospital	Denver	0	18	0%	0
Denver Health Medical Center	Denver	7	33	21%	22
Swedish Medical Center	Denver	3	37	8%	5
Cedars-Sinai Medical Center	LA	3	41	7%	2
Harbor UCLA Medical Center/LAC	LA	14	61	23%	26
USC Medical Center	LA	22	81	27%	19
UCLA Medical Center	LA	10	28	36%	17
UCI Medical Center	LA	8	35	23%	18

Appendix E: Citywide percent of hospitals on EMS Diversion (requesting ambulances to go elsewhere)

City	Overall Rate of Diversion for Previous Month	Rate of Diversion at 4:30 PM on March 25, 2008
New York City	4%	5%
Los Angeles	28%	21%
Washington D.C.	8%	22%
Chicago	8%	8%
Houston	15%	13%
Denver	6%	8%
Minneapolis	2%	7%

Appendix F: Estimated annual loss of federal Medicaid funds to Level I trauma centers, by hospital (in millions)

Hospital Name	City	Cost Limit Rule	GME Rule	Outpatient Hospital Rule	Total Federal Funding at Risk	Total Federal Funding at Risk, as % FY07 Budget
Bellevue Hospital Center	NYC	24	28	8	59	10%
Elmhurst Hospital Center	NYC	17	19	6	42	9%
Harlem Hospital Center	NYC	11	14	4	29	9%
Jacobi Medical Center	NYC	19	25	6	50	11%
Kings County Hospital Center	NYC	21	24	7	52	9%
Lincoln Medical and Mental Health Center	NYC	15	25	5	45	11%
New York Presbyterian Hospital	NYC	None	63	NS	63	2%
St. Lukes Roosevelt Hospital	NYC	None	9	None	9	1%
Staten Island University Hospital	NYC	None	6	NS	6	1%
Stony Brook University Hospital	NYC	9	8	NS	16	2%
St. Vincents Manhattan	NYC	None	13	NS	13	3%
Winthrop University Hospital	NYC	None	1	NS	1	0.2%
John H. Stroger Hospital of Cook County	Chicago	25-35	4	NS	29-39	8% -11%
Northwestern Memorial Hospital	Chicago	None	None	1	1	0.1%
Ben Taub General Hospital	Houston	49-61	None	None	49-61	6%
Memorial Hermann Hospital	Houston	None	None	NS	NS	NS
University of Texas Medical Branch	Houston	20	4	0.2	25	4%
Denver Health Medical Center	Denver	30-40	0.4	NS	30 - 40	6% - 8%
Cedars-Sinai Medical Center	LA	None	None	NS	NS	0.6%
Harbor UCLA Medical Center/LAC	LA	20	1	NS	21	5%
USC Medical Center	LA	40	11	NS	51	5%
UCLA Medical Center	LA	12	4	1	17	2%
UCI Medical Center	LA	13	2	1	15	3%
Total*		**326-357**	**260**	**38**	**623-654**	

*Totals may not add up by column due to rounding. "None" indicates that the hospital did not believe that rule would have a financial impact. "NS" indicates "not specified", meaning that no answer was provided.

Appendix G: Hospital comments on financial impact

I. New York Presbyterian Hospital, New York:
"This order of reductions threaten hospitals' ability to fund replacement of existing equipment and future capital projects, let along routine operations. At NYPH, excluding investment returns, the hospital's margin was under 2% on close to $3 billion in operations."

II. John H. Stroger Hospital of Cook County, Chicago:
"Stroger Hospital is, by far, the largest public hospital in the State and the region; loss of resources of this magnitude inevitably will lead to curtailing of critical health care safety net services such as emergency, trauma, burn, HIV/AIDS, neonatology, asthma care, diabetes care, and many others; Stroger Hospital is the regional cornerstone of specialty care access for both Medicaid and uninsured patients in the metropolitan area - loss of revenues from the rule(s) would lead to diminished specialty care access for those most in need; In all, the public health of the community will be adversely affected by many measures…"

III. Ben Taub General Hospital, Houston:
"The Hospital district will have to significantly reduce services to the uninsured and indigent patients of Harris County in order to bring the cost of services provided in line with funds available."

IV. Denver Health Medical Center, Denver:
"The impact of these regulations, if implemented, will be to devastate the Colorado safety net system requiring Colorado's safety net hospitals to substantially decrease care to the uninsured."

V. USC Medical Center, Los Angeles:
"The impact of these regulations will undoubtedly result in reduced inpatient and outpatient services in Los Angeles County. Decreased access will result in further impacts to emergency rooms already overwhelmed by increasing patient volumes."

Appendix H: Emergency Department Survey

UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
EMERGENCY DEPARTMENT SURVEY

The Committee on Oversight and Government Reform is conducting a survey of level I trauma centers in seven metropolitan areas: New York City, Washington D.C., Chicago, Houston, Denver, Minneapolis, and Los Angeles. This survey will help to assess the current state of emergency department capacity across the country, and the potential impact of these policy changes on emergency care.

Please complete Part IIA of the following survey, and return your answers to the Committee on Oversight and Government Reform on or before March 25th, 2008. Part IIB of the survey will be completed by telephone on Tuesday, March 25th, 2008. Please review these questions and be prepared to provide data for your hospital and emergency department. **Some of questions may require input from a nursing coordinator or bed-board administrator.**

Consistent with the Committee's policy on transparency, the answers you provide should not be considered to be confidential. If you have any questions regarding this survey, please feel free to contact Stephen Cha, M.D. of the Committee staff at (202) 225-5056.

PART A

Hospital Name: _____
Survey Respondent Name: _____
Survey Respondent Title: _____

1. In your emergency department (ED), how many standard treatment spaces do you have? *Standard treatment spaces include beds or treatment spaces specifically designed for ED patients to receive care, not including overflow spaces.* _____

2. In your hospital, what is the total number of available trauma bays in the emergency department? *Available beds are beds that are licensed, set up and available for use. Available beds may or may not be staffed.* _____

3. Does your hospital have a burn unit? _____

   What is the total number of available burn unit beds? _____

4. Is your hospital a sponsor or major affiliate for an emergency medicine residency training program? _____

   If yes, how many total residents are currently training in this program? _____

5. Does your hospital have other residency programs (*e.g. internal medicine, general surgery)* whose residents rotate through your emergency department? _____

6. Do you personally know of patients in your emergency department who have been harmed by excessive crowding or wait times? If you would like to share a personal anecdote, please attach

additional page(s). _____

7. In the past year, what is the most unusual treatment space you have used to care for an emergency room patient? _____

The following question may require input from a nursing coordinator or bed-board administrator.

8. In your hospital, what is the total number of available acute care beds? *Please do not include obstetric, pediatric, or psychiatric beds in your response.* _____

   Regular "ward" beds _____

   Telemetry or "step-down" beds _____

   Intensive care/critical care beds _____

PART B

For this survey, "currently" means at 4:30 p.m. on March 25th, 2008.

1. How many patients are currently undergoing evaluation and treatment in the ED? _____

   How many of your current ED patients are being treated in an overflow treatment space? *Overflow spaces include chairs, stretchers in hallways, or other spaces not specifically designed for ED patients to receive care.* _____

2. How many ED patients are currently waiting to see a physician, physician assistant or nurse practitioner? _____

3. How many ED boarders do you currently have? *Boarders are patients for whom the final decision to admit or transfer to another hospital has been made, but who have not yet left the ED.* _____

4. Among your current boarders, what is the longest period of time that a patient has been boarding? _____

5. In your emergency department, how many trauma bays are currently vacant, staffed and available? _____

6. Can your hospital go on diversion? *"On diversion" means that your ED or hospital has requested that ambulances bypass your ED and transport patients you would normally have been capable of seeing to another medical facility.* _____

7. Is your hospital currently on diversion? _____

8. Why is your hospital currently on diversion:

   Lack of trauma capacity ☐

   Lack of critical care capacity ☐

Lack of acute care bed care capacity ☐

Other _____

9. In the preceding week, how many hours did your hospital spend on diversion for any reason? _____

10. How many of the following personnel are currently staffing the ED? _____

    Total registered nurses? _____

    Registered nurses providing direct patient care? _____

    Attending physicians? _____

    Nurse practitioners? _____

    Physician assistants? _____

11. How many residents/interns are currently on duty in the ED? _____

The following questions may require input from a nursing coordinator or bed-board administrator.

12. In your hospital, how many total beds are currently vacant, staffed and available? *Please do not include obstetric, pediatric or psychiatric beds.* _____

    Regular "ward" beds _____

    Telemetry or "step-down" beds _____

    Intensive care/critical care beds _____

    Burn unit beds _____

13. At the current time, how many patients are waiting for an ICU bed? *These patients may be waiting in the ER, PACU, recovery room, or other units not normally used to provide inpatient ICU care.* _____

Appendix I: Financial Impact Survey

UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
FINANCIAL IMPACT SURVEY

Name of Institution: _____

Name of Individual Completing Survey: _____

Title of Individual Completing Survey: _____

For the purposes of this survey, we ask that you assume that the proposed Medicaid regulations[1] will take effect. Consistent with the Committee's policy on transparency, the answers you provide should not be considered to be confidential.

1. Please provide projected one-year estimates for the total amount of funding (federal and state) for your institution that would be put at risk by the following. If necessary, please include the range of funding at risk.

   Cost Limit Final Rule (public providers only) _____

   GME Rule (if applicable) _____

   Outpatient Rule _____

   Total _____

2. The total projected funding at risk, as described above, would translate to what percentage of your FY07 total budget?

   _____

3. Is there anything else we should know about the projected financial impact of these Medicaid regulations for your hospital?

Thank you for your participation.

[1] The Cost Limit for Public Providers Rule (CMS 2258-FC, 72 FR 29748) narrows the definition of a public provider and limits payments to public providers to the cost of treating Medicaid patients.

The Payments for Graduate Medical Education (GME) Rule (CMS 2279-P, 72 FR 28930) prohibits federal matching funds for costs of GME programs as part of Medicaid reimbursement for inpatient or outpatient hospital services.

The Outpatient Hospital Services Rule (CMS 2213-P, 72 FR 55158) narrows the scope of Medicaid outpatient hospital services to Medicare outpatient hospital services paid on a prospective basis and excludes other outpatient Medicaid services from coverage.

Further information can be found at http://oversight.house.gov/documents/20080303111450.pdf.

SNAPSHOT OF EMERGENCY SURGE CAPACITY IN NEW YORK CITY

At 4:30 p.m. on Tuesday, March 25, 2008, the majority staff of the Committee on Oversight and Government Reform surveyed 34 Level I trauma centers in seven cities, including the New York City, New York area.[1] Level I trauma centers are hospitals that have the staff and facilities to offer the most comprehensive, around-the-clock trauma care. This snapshot survey found that there was little or no emergency surge capacity — the ability to handle a sudden influx of casualties — in the Level I trauma centers in any of the seven cities.

Sixteen of the 21 Level I trauma centers that serve over 12.6 million residents in the New York City area participated in the survey. New York City is classified by the Department of Homeland Security (DHS) as a Tier I city — a designation given to "high-threat, high-density urban areas" that are at the "highest risk" for acts of terrorism.[2]

The survey assessed the capacity of the Level I trauma centers in New York City to respond to a terrorist bombing of a size similar to the 2004 Madrid bombing. According to the Centers on Disease Control and Prevention, the 2004 Madrid bombing, in which over 2,000 were injured and more than 270 patients were taken to one hospital within 2.5 hours, is an appropriate standard for assessing mass casualty preparedness.[3]

The survey found that on Tuesday, March 25, 2008, at 4:30 p.m. local time:

- **More than half of the emergency rooms in the Level I trauma centers surveyed in New York City were operating above capacity.** When an emergency room reaches "capacity," new patients can be accommodated only in overflow spaces, such as hallways, waiting rooms, or administrative offices. Of the 16 Level I trauma centers surveyed in New York City, ten were operating over capacity, meaning they had no available treatment space in the emergency room to accommodate new patients. The average emergency room was operating at 114% of capacity in the Level I trauma centers in New York City.

- **The total number of available treatment spaces in the emergency rooms of the Level I trauma centers surveyed in New York City was insufficient to respond to a Madrid event.** After the Madrid attack, 270 victims were transported to one hospital for emergency care. New York City did not have sufficient treatment spaces in emergency rooms of their Level I trauma centers to handle the volume of victims treated at one Madrid hospital. In total, the emergency rooms in the 16 Level I trauma centers in New York City had only 56 available treatment spaces, less than 21% of the demands faced by a single hospital in Madrid on the day of the bombing.

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[1] Committee on Oversight and Government Reform Majority Staff, *Emergency Surge Capacity: The Failure to Prepare for the "Predictable Surprise"* (May 5, 2008). The other cities are Los Angeles, Chicago, Washington, D.C., Houston, Denver, and Minneapolis.

[2] Department of Homeland Security, *Tier I Urban Area Security Initiative Jurisdictions* (online at www.dhs.gov/xlibrary/assets/grants-2007-program-overview-010507.pdf).

[3] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. *In a Moment's Notice: Surge Capacity for Terrorist Bombings* (Apr. 2007).

Surge capacity depends on more than sufficient space in the emergency room. A hospital must also be able to provide sufficient critical care and inpatient resources, such as beds in intensive care units and burn units, and general inpatient beds. If these beds are not available, patients who require hospitalization are frequently "boarded" in the emergency room until they can be moved to an intensive care unit or inpatient bed. On the day of the survey, there were also acute shortages of these critical care and inpatient beds in the hospitals surveyed.

- **None of the Level I trauma centers surveyed in New York City had enough critical care capacity available to treat the casualties from a Madrid event.** After the Madrid attack, 29 patients arrived at one hospital in critical condition. None of the Level I trauma centers surveyed in New York City had the critical care capacity to handle this volume of severely injured victims. On average, the trauma centers surveyed had an average of only five intensive care unit beds available. Two hospitals (13%) had no available intensive care unit beds.

- **None of the Level I trauma centers had a sufficient number of regular inpatient beds available to absorb the casualties from a Madrid event.** In Madrid, 89 casualties required admission to a hospital bed. No Level I trauma center surveyed had enough beds available to accommodate a surge of this size. On average, the Level I trauma centers in New York City had only 23 beds available.

After conducting the "snapshot" survey on March 25 at 4:30 p.m., the Committee staff sent follow-up questionnaires to the hospitals surveyed. Twenty-three of the hospitals responded to the questionnaire. Their responses indicate that the level of emergency care they can provide is likely to be further compromised by three new Medicaid regulations, the first of which takes effect on May 26, 2008. According to these hospitals, the new Medicaid regulations will reduce federal payments to their facilities by $623 million per year. If the states choose to withdraw their matching funds, the hospitals could face a reduction of about $1.2 billion. The hospitals told the Committee that these funding cuts will force them "to significantly reduce services" in the future and that "loss of resources of this magnitude inevitably will lead to curtailing of critical health care safety net services such as emergency, trauma, burn, HIV/AIDS, neonatology, asthma care, diabetes care, and many others."

Twelve of the Level I trauma centers in New York City responded to this financial impact survey. Based on the estimates of the administrators who responded, these hospitals could lose a total of $384 million in federal funds each year as a result of these Medicaid regulations. If the state were also to withdraw matching funds, these two hospitals could lose as much as $768 million per year.

THE LACK OF HOSPITAL EMERGENCY SURGE CAPACITY: WILL THE ADMINISTRATION'S MEDICAID REGULATIONS MAKE IT WORSE? DAY TWO

WEDNESDAY, MAY 7, 2008

HOUSE OF REPRESENTATIVES,
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
Washington, DC.

The committee met, pursuant to notice, at 9:31 a.m., in room 2154, Rayburn House Office Building, Hon. Henry A. Waxman (chairman of the committee) presiding.

Present: Representatives Waxman, Cummings, Tierney, Norton, McCollum, Van Hollen, Murphy, Sarbanes, Davis of Virginia, Shays, Issa and Sali.

Staff present: Phil Barnett, staff director and chief counsel; Karen Nelson, health policy director; Karen Lightfoot, communications director and senior policy advisor; David Rapallo, chief investigative counsel; Andy Schneider, chief health counsel; John Williams, deputy chief investigative counsel; Sarah Despres, senior health counsel; Steve Cha, professional staff member; Earley Green, chief clerk; Zhongrui "JR" Deng, chief information officer; Leneal Scott, information systems manager; Kerry Gutknecht, William Ragland, Miriam Edelman, and Jennifer Owens, staff assistants; Sheila Klein, office manager/general assistant to the staff director; Larry Halloran, minority staff director; Jennifer Safavian, minority chief counsel for oversight and investigations; Keith Ausbrook, minority general counsel; Christopher Bright, Jill Schmaltz, Benjamin Chance, and Todd Greenwood, minority professional staff members; Patrick Lyden, minority parliamentarian and member services coordinator; and Ali Ahmad, minority deputy press secretary.

Chairman WAXMAN. The meeting will please come to order. Today we are holding the second of 2 days of hearings on the impact of the administration's Medicaid regulations on the ability of our Nation's emergency rooms to respond to a sudden influx of casualties from a terrorist attack.

On Monday we heard from the leading experts that the emergency rooms in our Nation's premier trauma centers have little or no surge capacity. We learned from them that many Level I trauma centers do not have the capacity to respond to a terrorist bombing like the one that happened in Madrid in 2004. And we learned that the administration's new Medicaid regulations are expected to make these problems worse by cutting off crucial funding.

The hearing left us with a number of important questions, which we hope to answer this morning. Why would the Department of

Health and Human Services, knowing that the Nation's emergency care system is already stretched to the breaking point, withdraw billions of Federal dollars from the hospitals that provide the most comprehensive emergency care to the most seriously injured? Why would the Department of Health and Human Services take this drastic step without first considering the impact of its actions on emergency preparedness or consulting with the agency with lead responsibility for homeland security? Why would the Department of Homeland Security, which is the Federal agency with lead responsibility for protecting the Nation from terrorist attacks, stand by while local emergency surge capacity is compromised?

The impact of the Medicaid regulations on our health care safety net is not a partisan issue. Last month Republicans in the House joined with Democrats in passing bipartisan legislation that would postpone the regulations and give Secretary Leavitt and Secretary Chertoff an opportunity to reevaluate their implications for homeland security.

The issue we are considering today is one that concerns all Americans: how to ensure that we have a robust response capacity in our emergency rooms. If the unthinkable happens, and we have learned that the unthinkable can happen, lives will be lost unless emergency care is immediately available. If a major city experiences a terrorist bombing like the one that occurred in Madrid, there will be a golden hour, an hour in which the fate of those who are injured will be determined, whether the most severely injured survive or die. The Federal Government's job is to do everything possible to ensure that emergency care resources are ready during that golden hour.

Certainly our government should not be taking actions that undermine the prospect of an effective emergency response. That is why we are having this hearing today, and that is why I look forward to the testimony of the two men in charge, Secretary Chertoff and Secretary Leavitt.

[The prepared statement of Chairman Henry A. Waxman follows:]

Opening Statement of Rep. Henry A. Waxman
Chairman, Committee on Oversight and Government Reform
The Lack of Hospital Emergency Surge Capacity: Will the Administration's Medicaid Regulations Make It Worse?
Day Two
May 7, 2008

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Certainly, our government should not be taking actions that undermine the prospect of an effective emergency response.

That is why we are having this hearing, and that is why I look forward to the testimony of Secretary Chertoff and Secretary Leavitt this morning.

Chairman WAXMAN. But before we go on, I want to recognize Mr. Davis for an opening statement.

Mr. DAVIS OF VIRGINIA. Well, thank you, Mr. Chairman. As you said, we are here today to discuss two issues, Medicaid reimbursement regulations and the hospital surge capacity in response to predictable, some say inevitable, mass-casualty events. And we are fortunate to have two very distinguished witnesses to inform our discussion. Welcome Secretary Leavitt and Secretary Chertoff. We appreciate your taking your valuable time to be with us today.

As we learned from Monday's testimony on these same subjects, the nexus between Medicaid payments to hospitals and emergency preparedness may seem intuitive, but it is not by any means proven. Extrapolating directly from daily emergency department utilization rates to catastrophic surge capacity overlooks complex and interrelated factors that differentiate single-facility financial management from the broader resources needed to mount a coordinated regional disaster response. But extrapolate the committee did in releasing a 1-day snapshot of hospital emergency room occupancy in seven major cities and concluding it painted a complete picture of surge capacity.

Consulting the issues of Medicaid reimbursement and terrorism preparedness simultaneously oversimplifies and obscures both issues. I happen to agree with Chairman Waxman, we ought to know more about the impact of the administration's proposed regulation changes before exacting further cost savings from an already stressed health care system. But wrapping that issue in the mantle of terrorism creates the false impression solving the problem of emergency room capacity on Tuesday means we are ready for doomsday. It does not. As one peer-reviewed study put it, surge capacity planning involves ensuring the ability to rapidly mobilize resources in reaction to such a sudden unexpected increase in demand regardless of baseline conditions.

It is just too simple and fiscally untenable to say there can never be cost savings in Medicaid as long as we are not ready for a Madrid-style attack. Both Medicaid efficiencies and preparedness need to be pursued, not one pitted against the other. So I hope we can move beyond limited snapshots and talk about the dynamic range of factors in addition to baseline facility funding that make up real surge capacity organization, leadership, standards of care, medical education and training, interoperable communications, transportation coordination and information technologies.

Finally, we appreciate the fact that our witnesses made a tough choice to be here today. As we speak, the Federal Government is conducting a national continuity of operations exercise, testing many of the response elements needed to treat a surge of trauma patients. I hope the exercise goes well in their absence, and trust the committee's approach to these issues will continue to be constructive and supportive of executive branch efforts to prepare the Nation for catastrophic events. Thank you.

Chairman WAXMAN. Thank you very much, Mr. Davis.

[The prepared statement of Hon. Tom Davis follows:]

HENRY A. WAXMAN, CALIFORNIA
CHAIRMAN

TOM DAVIS, VIRGINIA
RANKING MINORITY MEMBER

ONE HUNDRED TENTH CONGRESS

Congress of the United States
House of Representatives
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
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Minority (202) 225–5074

Statement of Rep. Tom Davis
Ranking Republican Member
Committee on Oversight and Government Reform
"The Lack of Hospital Emergency Surge Capacity: Will the Administration's Medicaid Regulations Make it Worse?"
May 7, 2008

Thank you, Mr. Chairman. As you said, we're here to discuss two issues this morning: Medicaid reimbursement regulations and hospital "surge capacity" in response to predictable, some say inevitable, mass casualty events. And we're fortunate to have two very distinguished witnesses to inform our discussion. Welcome Secretary Leavitt and Secretary Chertoff. We appreciate their taking time to be with us.

As we learned from Monday's testimony on these same subjects, the nexus between Medicaid payments to hospitals and emergency preparedness may seem intuitive, but it is by no means proven. Extrapolating directly from daily emergency department utilization rates to catastrophic surge capacity overlooks complex and interrelated factors that differentiate single facility financial management from the broader resources needed to mount a coordinated regional disaster response.

But extrapolate the Committee did in releasing a one-day "snapshot" of hospital emergency room occupancy in seven major cities and concluding it painted a complete picture of surge capacity. Conflating the issues of Medicaid reimbursements and terrorism preparedness simultaneously oversimplifies and obscures both issues. I happen to agree with Chairman Waxman we ought to know more about the impact of the Administration's proposed regulation changes before exacting further cost savings from an already stressed health care system. Wrapping that issue in the mantle of terrorism, however, creates the false impression solving the problem of emergency room capacity on Tuesday means we're ready for Doomsday. It does not. As one peer-reviewed study put it, "Surge capacity planning involves ensuring the ability to rapidly mobilize resources in reaction to such a sudden, unexpected increase in demand, *regardless of baseline conditions*...." (emphasis added) It's just too simple, and fiscally untenable, to say there can never be cost savings in Medicaid as long as we're not ready for a Madrid-style attack. Both Medicaid efficiencies and preparedness need to be pursued; not one pitted against the other.

So, I hope we can move beyond limited snapshots and talk about the dynamic range of factors – in addition to baseline facility funding – that make up real surge capacity: organization, leadership, standards of care, medical education and training, interoperable communications, transportation coordination and information technologies.

Finally, we appreciate the fact our witnesses made a tough choice to be here today. As we speak, the federal government is conducting a national continuity of operations exercise testing many of the response elements needed to treat a surge of trauma patients. I hope the exercise goes well in their absence, and trust the Committee's approach to these issues will continue to be constructive and supportive of executive branch efforts to prepare the nation for catastrophic events.

Chairman WAXMAN. Because of time constraints, we will leave the record open for all Members to insert an opening statement in the record.

But we will go right to our very distinguished witnesses, and we are privileged to have both capable Secretaries with us today with distinguished careers in public service.

Secretary Michael Chertoff served as the Secretary of Homeland Security since February 2005. That capacity is a challenge. He has a challenging and critical responsibility to lead the Nation's efforts to prepared for, protect against, respond to and recover from terrorist attacks, major disasters and other catastrophic emergencies, whether man-made or natural disasters, that affect our homeland. And before taking the helm at the Department of Homeland Security, Secretary Chertoff served as a judge on the Third Circuit Court of Appeals. Prior to that he served as Assistant Attorney General of the Criminal Division at the Department of Justice.

Secretary Michael Leavitt has been the Secretary of the Department of Health and Human Services since January 2005. As Secretary of HHS, he is responsible for managing a daunting array of medical, public health and human services programs. HHS is the lead Federal agency for public health and medical preparedness and response. And before coming to HHS, Secretary Leavitt was the Administrator of the Environmental Protection Agency. He also served as Governor of Utah for three terms, and during his 11 years as Governor, Utah was recognized six times as one of America's best-managed States. We are pleased to have both of you here with us.

I don't know which one of you wants to go first. Secretary Leavitt—both of your prepared statements will be in the record in full. We would like to ask you to make your oral presentation to us now.

STATEMENT OF MICHAEL O. LEAVITT, SECRETARY OF HEALTH AND HUMAN SERVICES

Secretary LEAVITT. Good morning, Mr. Chairman. And thank you very much, Ranking Member Davis and other members of the committee. I am very pleased to discuss HHS leadership role in the public health and medical emergency preparedness efforts, as well as HHS and CMS efforts to ensure that Medicaid pays appropriately for services that are delivered to Medicaid recipients.

As you know, local, State and Federal agencies have a shared responsibility for ensuring that the Nation is prepared for emergencies. In that context permit me to briefly discuss a few of the emergency preparedness efforts that are currently being led by HHS.

On October 18, 2007, President Bush signed the Homeland Security Presidential Directive No. 21 [HSPD–21]. It established a new national strategy for public health and medical preparedness. HSPD–21 mandates the development of an implementation plan. HHS chairs the interagency writing team that drafted the implementation plan that is currently in the process of being finalized.

As part of the implementation plan, HHS is implementing an Emergency Care Coordinating Center. This new center will serve as a coordinating focal point for emergency care as an enterprise.

The ECC, as we have come to know it, charter is being finalized, and we anticipate to have the center up and running by the end of this year.

The National Response Framework Emergency Support Function [ESF] 8, titled the Public Health and Medical Services Function, provides a mechanism for coordinating Federal assistance to State, tribal and other local resources in response to a medical disaster.

The Secretary of Health and Human Services leads all of the Federal public health and medical response to public health agencies. The Secretary of HHS also coordinates through his Assistant Secretary or ASPR all of the ESF 8 preparedness, response and recovery actions. The National Disaster Medical System [NDMS], transferred from the Department of Homeland Security to HHS, remains the tip of the spear, if you will, as the Federal disaster health care response capacity.

Over the past 5 years, the Hospital Preparedness Program has provided more than $2.6 billion to fund the development of medical surge capacity at the State and local level. As part of our pandemic planning, we have asked grantees to report participating hospitals' ability to track beds electronically, to report to the grantee's emergency operations center within 60 minutes of a request.

From 2002 to 2007, the Public Health Emergency Preparedness Program has provided $5.6 billion to State, local, tribal and territorial public health departments. This program has greatly increased the preparedness capabilities of the public health departments.

Now turning briefly to Medicaid, it is important to remember that Medicaid is fundamentally a Federal-State commitment to provide health care for Medicaid beneficiaries. First and foremost, our responsibility is to assure that these low-income children, pregnant women and people with disabilities are able to receive high-quality and appropriate care when they need it.

The package of recent Medicaid regulatory activity will help enable, or to ensure rather, that Medicaid is paying providers appropriately for services delivered to Medicaid recipients, and that those services are effective, and that taxpayers are receiving the full value of the dollars that are spent through Medicaid.

GAO and the Office of Inspector General at HHS have provided policymakers with numerous reports on various areas in which States inappropriately engage in activities that maximize Federal revenues. These rules address these types of abuses head on. It addresses them by ensuring that the Federal Medicaid dollars are matching actual State payments for actual Medicaid expenses to actual Medicaid beneficiaries. Medicaid is already an open-ended Federal commitment for Medicaid services for Medicaid recipients. It should not become a limitless account for State and local programs and agencies to draw Federal funds for non-Medicaid purposes.

In conclusion, as I have mentioned earlier, HHS is working diligently to improve our Nation's emergency preparedness and our medical surge capacity, and we have made extensive funding available to hospitals through the States specifically to this end.

Medicaid, however, is fundamentally a partnership that relies on both States and the Federal Government to contribute their share

of the cost of the program. Allowing for the continuation of abusive practices that shift costs to the Federal Government is not an appropriate way to ensure our Nation's preparedness. We are committed through our emergency preparedness efforts to continue to make progress and to make funding available to States while acting through these Medicaid rules to provide greater stability in the program and equity to the States. And I want to thank you for the opportunity of being here to testify.

Chairman WAXMAN. Thank you, Secretary Leavitt.

[The prepared statement of Secretary Leavitt follows:]

Testimony
Before the House Oversight and Government Reform Committee
United States House of Representatives

HHS Leadership in Federal Emergency Preparedness Efforts

Statement of
Michael O. Leavitt
Secretary
U.S. Department of Health and Human Services

For Release on Delivery
Expected at 10:00am
May 7, 2008

Good morning Chairman Waxman, Ranking Member Davis, and other distinguished Members of the Committee. I am pleased to discuss HHS leadership in Federal public health and medical emergency preparedness efforts, as well as HHS and CMS efforts to ensure that Medicaid pays appropriately for services delivered to Medicaid recipients, that those services are effective, and that taxpayers are receiving the full value of the dollars spent through Medicaid.

Emergency Preparedness

Local, state, and federal agencies have a shared responsibility for ensuring that the nation is prepared for emergencies. Before an event, government agencies at all levels work with the private sector to plan and exercise so they can be ready when a disaster occurs. During an emergency, local and state response agencies, including public health departments, are the first to respond. For multi-state or severe emergencies, the federal government may be asked to provide additional resources and coordinate response efforts across multiple jurisdictions. In that context, permit me to briefly discuss a few of the emergency preparedness efforts currently being led by HHS that involve working with our Federal, State, and local partners.

Homeland Security Presidential Directive (HSPD)-21

On October 18, 2007 President Bush signed Homeland Security Presidential Directive (HSPD)-21, "Public Health and Medical Preparedness," establishing a new National Strategy for Public Health and Medical Preparedness (the

Strategy). The Strategy aims to improve the Nation's ability to plan for, respond to, and recover from public health and medical emergencies at the Federal, State, Territorial, Tribal, and local levels. It calls for the continued development of a National Health Security Strategy, as well as a robust infrastructure -- including healthcare facilities, responders and providers -- which can be drawn upon in the event of an emergency. The Strategy also requires actions to ensure the adequate flow of information before, during, and after an event, including critical biosurveillance data and risk analysis. Finally, the Strategy calls for the development of resources at the community level to ensure that individuals and families are empowered to protect themselves in the event of an emergency.

In order to implement the actions outlined in the Strategy, the HSPD establishes an interagency Public Health and Medical Preparedness Task Force, led by the Secretary of Health and Human Services. In December 2007 an Assistant Secretary-level meeting of the 12 Departments that make up the Task Force was convened. Since then, HHS's Office of the Assistant Secretary for Preparedness and Response (ASPR) has chaired two interagency Action Officer level meetings to provide guidance on implementation.

HSPD-21 mandates the development of an Implementation Plan, which provides detailed information regarding how the Federal Departments and Agencies will execute these actions. HHS chairs the interagency Writing Team that drafted the Implementation Plan, which is currently in the process of being finalized.

Six workgroups have been established to oversee implementation of HSPD-21. Four workgroups are being chaired by HHS: (1) Medical Countermeasure Stockpiling and Distribution; (2) Biosurveillance; (3) Mass Casualty Care; and (4) Community Resilience. A fifth workgroup on Education and Training is co-chaired by HHS and DOD and a sixth workgroup on Risk Awareness is being chaired by the Department of Homeland Security.

HSPD-21 directed the establishment of two advisory committees. The National BioSurveillance Advisory Committee has been established as a subcommittee to the Centers for Disease Control and Prevention (CDC) Advisory Committee to the Director (ACD) and a Disaster Mental Health Advisory Committee is being established as a subcommittee under the National Biodefense Science Board (NBSB) which advises the HHS Secretary.

Emergency Care Coordination Center (ECCC)

Finally, HHS is implementing HSPD #21, including through the establishment of the Emergency Care Coordination Center (ECCC). This new center, an intradepartmental and interdepartmental collaborative effort involving the Departments of Defense, Homeland Security, Transportation and Veterans Affairs, will serve as the coordinating focal point for an Emergency Care Enterprise, coordinating with the Federal Interagency Committee on Emergency Medical Services. Its vision is exceptional daily emergency care for all persons of the United States and its mission is to promote Federal, State, local, tribal and

private sector collaboration to support and enhance the nation's emergency medical care.

The ECCC will assist the USG with policy implementation and guidance on daily emergency care issues and promote both clinical and systems-based research. Through these efforts, ASPR and its federal partners will improve the effectiveness of pre-hospital and hospital based emergency care by leveraging research outcomes, private sector findings and best practices. The ECCC will promote improved daily emergency care capabilities to improve resiliency of our local community healthcare systems. This will provide a stronger foundation on which to advance disaster preparedness efforts and strengthen our Nation's ability to respond to mass casualty events. Currently, the ECCC Charter is being finalized and we anticipate having the Center up and running by the end of the year.

Emergency Support Function 8 (ESF#8)

The National Response Framework (NRF) Emergency Support Function (ESF) #8 – Public Health and Medical Services – provides the mechanism for coordinated Federal assistance to supplement State, tribal, and local resources in response to a public health and medical disaster, potential or actual incidents requiring a coordinated Federal response, and/or during a developing potential health and medical emergency. The Secretary of Health and Human Services (HHS) leads all Federal public health and medical response to public health

emergencies and incidents covered by the *NRF.* The response addresses medical needs and other functional needs of those requiring medical care and other assistance during an emergency.

Except for the personnel and assets under armed forces command, the Secretary of HHS assumes operational control of Federal emergency public health and medical response assets, as necessary, in the event of a public health emergency. The Secretary of HHS, through ASPR, coordinates national ESF #8 preparedness, response, and recovery actions.

National Disaster Medical System (NDMS)

We are also continuously improving HHS's operational capabilities to respond to emergencies. The National Disaster Medical System (NDMS), transferred from the Department of Homeland Security to HHS, remains the "tip of the spear" as the federal disaster healthcare response capability, maintaining 6,200 medical and public health professionals and over 1,800 participating hospitals with approximately 32,000 beds. Since the transfer of NDMS last year, we have achieved a number of accomplishments aimed at improving the System including the integration of NDMS into the larger Emergency Support Function #8 (ESF-8) response framework and regionalization of NDMS response operations and caches to provide increased accountability and standardization for supplies as well as fiscal savings. Future goals for NDMS include enhancing readiness and

accountability through regionalization of NDMS response operations and enhancing equipment caches.

Hospital Preparedness Program (HPP)

We have made considerable investments in building the healthcare preparedness and response capabilities required during an incident resulting in mass casualties, and are committed to performance measurement. Over the past five years, the Hospital Preparedness Program (HPP) has provided more than $2.6 billion to fund the development of medical surge capacity and capability at the State and local level. As a result of HPP funds awarded to states and territories, hospitals and other healthcare entities:

- Increased their ability to provide needed beds during an emergency;
- Can now track bed and resource availability using electronic systems;
- Engaged with other responders through interoperable communication systems;
- Appropriately train their healthcare workers for all-hazards approach to emergencies,
- Protect their healthcare workers with proper equipment;
- Have installed equipment necessary to decontaminate patients;
- Have developed fatality management and hospital evacuation plans, and
- Coordinate regional exercises.

Pandemic and All-Hazards Preparedness Act (PAHPA)

Consistent with requirements contained in the Public Health Service Act, as amended by the Pandemic and All-Hazards Preparedness Act (PAHPA), HHS has updated the performance measures for our funding programs. Specific improvements include greater clarity in language, the use of definitions, and the addition of targets. For example, in FY 2006, HHS asked grantees to report participating hospitals' ability to track bed status electronically, and report it to the grantee's Emergency Operations Center within 60 minutes of a request. In 2007, the numerator and denominator were defined to improve clarity. For FY 2008, the target percentage of hospitals able to report was increased to 100 percent by the end of the end of the year.

HHS strongly supported the new accountability provisions included in PAHPA and is implementing these provisions. First, FY 2009 award funds will be based on the successful achievement of targets during the previous budget cycle. In addition, the matching provision will be applied to the Public Health Emergency Preparedness Program (PHEP) in FY 2009. We also intend, through notice and comment, to apply the matching provision to the Hospital Preparedness Program (HPP) in FY 2009. The audit and carryover provisions apply to both the PHEP and HPP programs currently; the withholding provision will be applied to these programs in FY 2009. The HPP and PHEP programs implemented the maintenance of funding provision in FY 2007.

Public Health Emergency Preparedness (PHEP) Program

From FY 2002- FY 2007, the Public Health Emergency Preparedness (PHEP) program has provided $5.6 billion to state, local, tribal, and territorial public health departments. This amount includes targeted supplements to prepare for smallpox (in FY 2003) and for an influenza pandemic (FY 2005 – FY 2007). This program has greatly increased the preparedness capabilities of public health departments:

- All states can receive and evaluate urgent disease reports 24/7, while in 1999 only 12 could do so.
- All states now conduct year-round influenza surveillance.
- The number of state and local public health laboratories that can detect biological agents as members of CDC's Laboratory Response Network (LRN) has increased to 110 in 2007, from 83 in 2002. For chemical agents, the number increased to 47, from 0 in 2001. Rather than having to rely on confirmation from laboratories at CDC, LRN laboratories can produce conclusive results. This allows local authorities to respond quickly to emergencies.
- All states have trained public health staff roles and responsibilities during an emergency as outlined in the Incident Command System, while in 1999 only 14 did so.
- All states routinely conduct exercises to test public health departments' ability to respond to emergencies. Such exercises were uncommon before PHEP funding.

Preserving the Medicaid Partnership

Medicaid, along with Medicare and other private payers, is an important source of funding for the American health care system. It is important to remember, however, that Medicaid is fundamentally a Federal-State commitment to provide health care for Medicaid beneficiaries. And, first and foremost, our responsibility is to assure that these low-income seniors, children, pregnant women, and people with disabilities are able to receive high quality and appropriate care when they need it.

The package of recent Medicaid regulatory activity will help ensure that Medicaid is paying providers appropriately for services delivered to Medicaid recipients, that those services are effective, and that taxpayers are receiving the full value of the dollars spent through Medicaid. As CMS and others have previously testified, there is a long and complicated history that is marked by States seeking to shift funding of the Medicaid program, to the greatest extent possible, to the Federal government. Federal recognition of this occurrence dates back to at least 1991 when Congress enacted prohibitions on provider taxes and donations.

Additionally, GAO and OIG have provided policymakers with numerous reports on various areas in which States engage in activities to maximize Federal revenues. Here are just a few examples:

- The GAO found several States "used several financing approaches to maximize federal Medicaid contributions without effectively committing

their share of matching funds. Under these approaches, facilities that received increased Medicaid payments from the states, in turn, paid the states almost as much as they received. Consequently, the states realized increased revenue that was used to reduce their state Medicaid contributions, fund other health care needs, and supplement general revenue funding."

- State agencies paid private facilities under a per diem rate for providing room and board, rehabilitation counseling and therapy, educational, and other services to children in State custody, and based their claims on facilities' estimated costs rather than actual costs. This resulted in an increase of $58 million in Federal Medicaid reimbursements.
- Medicaid is frequently billed for costs related to transporting children from home to school and back on a given school day despite the fact that children are transported to school primarily to receive an education, not to receive medical services. In a 2004 review of one state, OIG found that more than 90 percent of transportation claims to Medicaid, made on behalf of almost 700 schools and preschool providers over the September 1, 1993 through June 30, 2001 period, were not in compliance with Federal and State regulations.

These rules address these types of abuses head-on by ensuring that Federal Medicaid dollars are matching actual State payments for actual Medicaid services to actual Medicaid beneficiaries. Medicaid is already an open-ended

Federal commitment for Medicaid services for Medicaid recipients; it should not become a limitless account for State and local programs and agencies to draw Federal funds for non-Medicaid purposes.

When Medicaid funds are diverted to purposes not expressly authorized by law, legislatures have not had the opportunity to determine if such funding is warranted or desirable. As a result, the legislative decision-making process is weakened. This is especially true at the State level as Medicaid now typically accounts for one out of every five dollars spent by States. The Medicaid program should be based on transparency and trust, not on hidden funding arrangements that result in a "don't ask, don't tell" relationship with oversight agencies.

CMS is often asked why we cannot simply stop these practices through the audit and disallowance process. Audits and disallowances occur on the back end of the process. Obviously it would be better if there were no opening for practices that are inconsistent with the overall statutory and regulatory framework. The rules listed below would help eliminate perceived ambiguities and protect the federal-state financial partnership.

Final Medicaid Governmental Provider Payment Rule

The Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership rule requires that Medicaid payments to governmentally-operated health care providers not exceed

an individual provider's cost. This will ensure that the Federal government pays only its share for Medicaid services delivered by that provider. This reform is critical to strengthening program accountability, consistent with GAO and OIG recommendations.

To the extent that a provider is not governmentally operated, this rule does not impact Medicaid payments made to them by the State. The rule would simply offer further protection against States requiring non-governmental providers to assist in the funding of the Medicaid program as well as clearly stating that the provider must retain all of the Medicaid payments it receives. To the extent that a provider is governmentally operated, this rule stipulates that the provider is entitled to receive Medicaid payments up to their full cost of providing services to Medicaid eligible individuals.

The Federal government is not reducing, restricting, or limiting the Federal commitment to pay the full cost of providing medically necessary services to Medicaid recipients as long as the States are contributing their full share as well.

Proposed Rule on Graduate Medical Education

The proposed rule makes Medicaid graduate medical education (GME) payments and costs ineligible for Federal financial participation (FFP). Specifically, the proposed rule no longer allows States to include GME as a payment under the Medicaid State plan or as an allowable cost in determining

Medicaid payments. There is no explicit authorization under the Medicaid statute to subsidize the training of physicians. In a time of limited Federal and State resources, it is important to prioritize Medicaid spending and target it to its primary purpose.

Final Rule on Provider Taxes

This final rule (1) revises the threshold from 6 percent of net patient revenue to 5.5 percent under the first prong of the indirect hold harmless guarantee test as enacted by the Tax Relief and Health Care Act of 2006 (TRHCA, P.L. 109-432); (2) clarifies the standard for determining the existence of a hold harmless arrangement under the positive correlation test, Medicaid payment test, and the guarantee test; (3) codifies changes to permissible class of health care items or services related to managed care organizations (MCO) as enacted by the Deficit Reduction Act of 2005 (DRA, P.L. 109-171); and (4) removes obsolete transition period regulatory language. We believe that this rule faithfully reflects the intent of Congress in enacting the provider tax rules in 1991 and the minor revision in TRHCA.

Proposed Rule on the Clarification of Outpatient and Clinic Upper Payment Limit

The proposed regulation intends to clarify the current vague regulatory language in order to define the scope of Medicaid outpatient hospital services and the UPL for those services. The regulation intends to prevent an overlap between outpatient hospital services and other covered benefits. The potential overlap

could result in circumstances in which payment for services is made at the high levels customary for outpatient hospital services instead of the levels associated with the same services under other covered benefits.

The rule recognizes services paid under the Medicare outpatient prospective payment system or paid by Medicare as an outpatient hospital service under an alternative payment methodology as Medicaid outpatient hospital services. The scope of Medicaid outpatient hospital services may not include a service reimbursed under a distinct State plan payment methodology for another Medicaid covered service. The rule also limits the facilities that may provide outpatient hospital services to hospitals and departments of an outpatient hospital.

Final Rule on the Elimination of Reimbursement for Administrative Claiming and Transportation Costs for School-Based Services

This rule clarifies that administrative activities performed by schools are not necessary for the proper and efficient administration of the State Medicaid plan. The rule also specifies that transportation of students from home to school and back is not within the scope of allowable Medicaid-related transportation recognized by the Secretary. Therefore, under the rule, funding for the costs of these activities or services performed would no longer be available under the Medicaid program. States will continue to receive reimbursement under the Medicaid program for school-based Medicaid service costs under their approved State plans under current law.

Interim Final Rule with Comment on Targeted Case Management

The interim final rule clarifies the definition of covered case management services and implements Section 6052 of the Deficit Reduction Act of 2005, which redefined the scope of allowable case management services, strengthened State accountability, and required that CMS issue regulations. The work of GAO and the OIG was key to our understanding that some States were claiming case management expenditures that were not supported by actual activities to improve the health status of Medicaid recipients. It is important to remember that the point of the Medicaid program is to improve the availability of health services and the health status of program beneficiaries, not simply as a supplement for state and local budgets.

This interim final rule has a strong emphasis on ensuring that case management will be comprehensive and coordinated, to fully serve beneficiary needs. High quality case management should result in better outcomes for the individual and better value for the taxpayer.

Proposed Rule on Rehabilitative Services

In recent years, Medicaid rehabilitation services have increasingly become prone to inappropriate claiming and cost-sharing from other programs, because these services are so broadly defined as to become simply a "catch all" phrase. The proposed regulation clearly defines allowable services that may be claimed as "rehabilitative services."

This proposed rule will also include important beneficiary protections to improve the quality of care provided to the individuals who need these rehabilitative services. For the first time, rehabilitative services would be required to be furnished through a written plan of care that identifies treatment goals and methods. Our proposed rule contemplates that care will have a clear foundation in clinical practices, and will be designed and delivered in a patient centered environment.

Conclusion

These rules reflect the long-standing work of CMS and others, such as GAO and the OIG, to restore greater accountability to the Medicaid program, while safeguarding limited resources for actual services to those individuals who rely on the Medicaid program. As I have testified, HHS is working diligently to improve our nation's emergency preparedness and medical surge capacity, and we have made extensive funding available to hospitals through the states specifically toward this end.

Medicaid, however, is fundamentally a partnership that relies on both sides to contribute their share to the cost of the program, and allowing for the continuation of abusive practices of shifting costs to the Federal government is not the appropriate way to ensure our nation's preparedness. As Medicaid competes for resources at the State level against all the other demands that are present, an

erosion of confidence in the integrity of the Medicaid program ultimately is not good for Medicaid or for the people who rely on it.

We are committed through our emergency preparedness efforts to continue to make progress and make funding available to states, while acting through these Medicaid rules to provide greater stability in the program and equity among the States.

Thank you for the opportunity to testify today; I am happy to take any questions you may have.

Chairman WAXMAN. Secretary Chertoff.

STATEMENT OF MICHAEL CHERTOFF, SECRETARY OF HOMELAND SECURITY

Secretary CHERTOFF. Thank you, Mr. Chairman. Good morning, Ranking Member Davis and other members of the committee.

Let me just take a few moments now since my full statement will be in the record to put into perspective what the role of the Department of Homeland Security is with respect to the issue of preparedness and response, one dimension of which, but only one dimension of which, is the issue of mass care in the event of some kind of a terrorist attack or natural disaster. But I also underscore the fact that the planning and execution of a response to an attack, particularly with respect to the issue of mass care, would implicate not only HHS, but would also require the participation of the Department of Defense and Department of Veterans Affairs. They have a major role to play in furnishing the resources and capabilities necessary to respond to a medical emergency, and their capabilities are built into our plan. So it is not merely a matter of HHS.

Basically what I would like do is describe the role that we play in any kind of a response, and, therefore, what role we play in planning in the lead-up to the possibility of a response. As you know, under the National Response Framework and the National Incident Management System, the Department of Homeland Security plays the role of incident coordinator, incident manager. That does not mean that we are exercising command and control over other departments and agencies. That would be prohibited as a matter of law.

What we do do is bring to the table the agencies that will play a role. There is a lead agency designated for particular functions; in the case of mass terrorists, the Department of Health and Human Services. That is a designation that is both prescribed by statute as well as by HSPD 5 and HSPD–21. Our role then would be to coordinate and deconflict the various capabilities that we bring to the table and the roles and responsibilities of the lead agency and other agencies, so that, for example, in the case of an attack, let's say a conventional attack, we would obviously have to coordinate the law enforcement response, although the lead agency there would be the Department of Justice. There might well be a security response, in which case we would be coordinating with the Department of Defense and the National Guard. And to the extent there was a mass casualty response, the mission assignment for carrying that out would be to HHS, but there would be support provided by the Department of Veterans Affairs and the Department of Defense. This is all done under the rubric of what we call Emergency Support Function 8, and the actual undertaking would be coordinated through the National Response Coordination Center.

As part of the preparation for this, we engage in a variety of planning exercises. And with respect to the issue of mass care, again we look to the Department of Health and Human Services to take the lead with respect to identifying what the gaps are with respect to potential surge capability, what the available resources are, and what are the most efficacious ways to provide those re-

sources. That is done with the understanding that the initial response obligation lies upon State and local public health officials. Therefore, they must participate in the planning, and it is their responsibility to make sure that they are planning in a way that is synchronized with us.

We also recognize, however, that these capabilities would likely be overwhelmed in 24 hours, or maybe 48 hours. That is why we have capabilities such as the National Disaster Medical System, which is run by HHS. We would look to the Department of Defense to provide mobile field hospitals and other kinds of medical capabilities, which we would move into the arena as quickly as possible. The National Guard would obviously play a major role. And, again, if there were some particular issue like a chemical attack or a dirty bomb attack, there would be specialized capabilities by the military that would be called into play.

So that is the general role that we play in coordinating these issues. We have engaged in planning, strategic planning, on a number of scenarios, including some with medical dimensions, again looking to HHS as the principal lead in identifying what the requirements are, identifying where the gaps are, and formulating a way in which those gaps can be plugged.

Thank you, Mr. Chairman.

Chairman WAXMAN. Thank you very much.

[The prepared statement of Secretary Chertoff follows:]

Statement for the Record

The Honorable Michael Chertoff

Secretary
United States Department of Homeland Security

Before the
United States House of Representatives
Committee on Oversight and Government Reform

May 7, 2008

Introduction

Good morning Chairman Waxman, Ranking Member Davis, and Members of the Committee. Thank you for the opportunity to participate in this hearing to discuss issues surrounding medical surge capacity and the effect of Medicaid regulations on the ability to respond in the event of a major disaster or other catastrophic incident.

I will address medical surge capacity within the scope of overall emergency preparedness and response capabilities, including national incident management doctrine. In particular, I will discuss the roles and responsibilities of the Department of Homeland Security (DHS), and highlight key areas of coordination between DHS and the Department of Health and Human Services (HHS).

It is important to note that the Department of Health and Human Services is the lead Federal agency for public health and medical preparedness and response issues and consequently coordinates and provides the actual health care and medical response in a major disaster or other catastrophic incident. The Department supports HHS in their mission.

Department of Homeland Security Responsibilities

The Department of Homeland Security's mission is to lead national efforts to prepare for, protect against, respond to, and recover from terrorist attacks, major disasters and other catastrophic emergencies whether manmade or natural disaster that affect the homeland. Should a catastrophic incident occur, DHS leads overall incident management activities.

Incident management, by definition, incorporates a variety of Departments across the Federal government, as well as State and local government and law enforcement; the actors involved depend on the type of incident. In turn, each department or agency, whether at the Federal or State and local level, has a particular role and mission. It is our role to coordinate and integrate all of those individual activities into an effective, coordinated, and timely response.

Medical surge capacity is a critical element of our local, state and national resiliency. When a large-scale natural or manmade disaster occurs, the ability to provide urgent and life-saving medical care, provided by resources from the local, state and federal levels, will have a direct correlation to the ability to save lives.

For example, if an improvised nuclear device or radiological dispersal device (i.e., a "dirty bomb") goes off in the middle of Manhattan or a biological agent is released in our Nation's capital, the capacity to handle a large number of causalities will be essential to managing the overall crisis and providing the necessary urgent care to those in need.

Many of our nation's medical facilities, including emergency departments and trauma centers, would be overwhelmed with individuals suffering from illnesses and injuries, ranging from relatively minor to life-threatening. HHS serves as the lead agency for coordinating the health response activities. It is our responsibility to facilitate that effective medical response within the

context of all the other demands of the event, such as the law enforcement, environmental, intelligence-gathering, public safety, communications, and search and rescue aspects.

In the event of a dirty bomb detonation, there will likely be numerous patients with multiple injuries from the bomb itself and related blast debris, such as glass, concrete and metal. This scene would also require additional care to address the issue of radiation contamination.

If a biological agent, such as an aerosolized form of anthrax, were disseminated over a wide area such as the Washington, D.C. metropolitan area, the city's medical capabilities would be severely tested. There would be little visible evidence of life-threatening injury, illness or other physical symptoms in the immediate aftermath of an anthrax release. We expect that many people will show up at local emergency departments to seek medical treatment, including those who have not been contaminated but are concerned they may have been exposed.

In this scenario, the Department's National Biosurveillance Integration Center (NBIC) would work with the intelligence community both before and after an event to identify the potential for a release and to help characterize the biological event if it did occur.

The fact that there may be little indication of a biological agent release early on is the reason a system of environmental sensors such as the DHS BioWatch program is critical to identifying that release before people become clinically symptomatic. Reaching exposed persons and providing them with appropriate antibiotics before they become clinically symptomatic is critical to saving lives.

Incident Management and Command

Homeland Security Presidential Directive (HSPD)–5 provides the framework for the Federal government's incident management system. HSPD-5 directs DHS to coordinate the Federal response in a major disaster or terrorist attack. The roles and responsibilities of Federal, state and local governments, law enforcement and the private sector are outlined in the National Response Framework (NRF) and in the 15 Emergency Support Functions (ESF), which include transportation, communications, health, law enforcement, and critical infrastructure.

Based on the National Incident Management System (NIMS), DHS is responsible for integrating the Federal response capabilities with our partners at the state, local and private sector levels to ensure a strong and interoperable national response. This system provides for a command, control and accountability structure among the multiple jurisdictions and disciplines that have to respond to large-scale events.

At the Federal level, response activities are coordinated by FEMA's National Response Coordination Center (NRCC). All of the lead agencies for the various Emergency Support Functions will have representatives present at the NRCC, including HHS as lead for ESF – 8 activities (*Public Health and Medical Services*). The NRCC includes representatives from FEMA and Office of Health Affairs (OHA), who interact directly with their counterparts from HHS to facilitate the necessary coordination for an effective medical response. Information from the NRCC is routinely fed to the National Operations Center where it is combined with

information from other agencies and open source media outlets to provide a common operating picture of an incident, thus giving full visibility to senior decision makers.

To be successful in fulfilling the DHS mission as the overall incident commander, we have to support others' abilities to fulfill their respective roles and responsibilities. For instance, we rely on the Department of Transportation to obtain key transportation-related information and provide appropriate resources to maintain transportation infrastructure. We rely on the Department of Defense and Army Corps of Engineers to provide support in coordinating and facilitating the delivery of their services and assessing public infrastructure and other resources. The Department of Justice is responsible for the characterization of a terrorist incident and to determine the source to prevent subsequent attacks. HHS is responsible for public health and medical issues.

It is not the responsibility of the Department of Homeland Security to direct our Federal partners to perform their specific roles and responsibilities when managing a major incident – for example, telling Health and Human Services specifically how to provide medical surge. It is the Department's responsibility to ensure that each of the agency roles and responsibilities are being met and coordinated in a major incident response.

Coordination with the Department of Health and Human Services

The authorities for mass casualty events are enumerated in several places, including the National Response Framework (NRF), Emergency Support Function (ESF) – 8: *Public Health and Medical Services*, HSPD-21 and the Public Health Service Act, and other statutory authorities. According to the NRF, HHS is the lead Federal agency in preparing, deploying and providing health and medical care to the public in the event of a disaster or other emergency.

Within DHS, the Office of Health Affairs and FEMA both work closely with the HHS Office of the Assistant Secretary for Preparedness and Response (ASPR) and the Centers for Disease Control and Prevention (CDC) on a daily basis to address the issues that affect our Nation's ability to effectively prepare for and respond to a major emergency.

State and Local Response

It is also important to highlight the essential role that state and local responders play in the immediate aftermath of a catastrophic event. Using the National Incident Management System (NIMS) model, these responders are required to manage on-scene activities from the moment of the event until Federal resources are able to arrive and become operational. Depending on the magnitude of the event, the response activities (including personnel, equipment and supplies) will expand from local health resources, to surrounding regions, to state resources, to adjoining state resources to Federal resources. Plans in place around the country incorporate these expanding assets.

DHS is committed to ensuring that the Federal response, whether it is a medical, environmental, or law enforcement response, for example, is well-coordinated with state and local officials to

ensure a seamless and integrated response. The role of the Federal government is to supplement the state and local efforts and to provide assistance when it is needed.

FEMA and the Office of Health Affairs work closely HHS and with states and local regions to assist in developing inter-state and multi-state agreements to provide supplies, hospital beds, medical professionals during a catastrophic event. These partnerships are important to ensure medical surge capacity.

Conclusion

Mr. Chairman, these are all very important issues. Medical surge capacity is a significant part of any effective national emergency preparedness and response capability. We are committed to working with our partners to ensure that these missions are fulfilled. I would be happy to answer any questions.

Thank you.

Chairman WAXMAN. Without objection, we are going to begin questioning with 10-minute rounds, first controlled by the Chair and second controlled by Mr. Davis. After that we will go back to the 5-minute rule.

I am going to start off the questions myself.

Secretary Leavitt and Chertoff, we are here to answer the very simple question, if we had a terrorist attack like what happened in Madrid, with conventional bombs or suicide bombers, which most terrorist experts say is most likely, not the unthinkable weapons of mass destruction, but if the unthinkable, unlikely terrorist attack using conventional weapons occurred, would we be prepared to deal with it?

Now, many experts have told us that if we had something like an attack on a commuter train where, as in Madrid, 177 people were killed and more than 2000 were injured, we wouldn't have the surge capacity in some of our major cities to deal with those people in the Level I trauma centers or even in the emergency rooms.

Secretary Chertoff, do you think we have the capacity to deal with such an attack?

Secretary CHERTOFF. I do, Mr. Chairman. Now, I want to note that HHS is currently engaged in a systematic survey of capacities and plans across the country, so there is going to be a definitive answer to this. And there is no doubt some communities are better prepared than others. But I don't have to speculate about it.

I remember we had a bridge collapse in Minneapolis some months ago. That was exactly the kind of event that you are talking about. It was not a terrorist event, but it was one which certainly posed challenges to casualties. My understanding is that in Minneapolis things worked very well.

Chairman WAXMAN. Thirteen people went to the emergency room under those circumstances. We could have hundreds, if not thousands, of people rushed into emergency rooms.

Secretary CHERTOFF. We have had air crashes, we have had other disasters. I can't give you a definitive statement with respect to a particular city. What I can tell you is I am not sure that the day-to-day capacity rates of emergency rooms is a prediction of the capability of the emergency system to deal with a disaster.

Chairman WAXMAN. Have you delegated that to HHS?

Secretary CHERTOFF. HHS has a principal responsibility, to my understanding.

Chairman WAXMAN. Well, let me read to you what your Chief Medical Officer Jeff Runge told the House Appropriations Committee last month. He said, "I don't think anybody who has looked would be under the mistaken notion that we are adequately prepared for a hospital surge. We have squeezed all the capacity out of the hospitals' budgets, and it's just not there."

He went on to say, "We frankly don't have a lot of solutions for it. Surge capacity does just not exist in the world of hospitals."

Mr. Runge did say the Federal assets could be brought to the scene of a bombing, as did you earlier, but that could take some period of time, maybe a day or more, which may be too long for many critically injured victims.

So your own expert does not think we are prepared. Why, do you disagree with Dr. Runge's assessment?

Secretary CHERTOFF. I wasn't here for the testimony. I think it depends on the number of people. If there are—I can certainly imagine an attack of a dimension that would overwhelm local resources. That is the very premise of what our position is with respect to planning. It is the recognition that the Federal Government would have to step in and surge. And obviously since we are doing a gap analysis, I am going to be the first person to tell you there are undoubtedly gaps that need to be plugged, some of which are planning, and some of which are capability gaps.

What I can't tell you is that this is simply a matter of emergency rooms. I think it is a much more complicated issue than that. I will also obviously acknowledge I am awaiting to get more precision in the results of the HHS study with respect to the country as a whole.

Chairman WAXMAN. Well, I don't doubt it is more complicated than one factor or another, but what I fear, and what the experts told us a couple days ago, is if we go ahead with these Medicaid cuts, withdrawing billions of dollars from hospitals that have Trauma I centers and emergency rooms, we will be making the problem worse. We will make it less sure that we can even meet the response that we found so inadequate in our survey on March 25th. At that time the staff called Los Angeles, and three of the five Level I hospitals that were so overcrowded, they simply shut their doors. There wasn't even a terrorist attack. They shut their doors and said divert these people somewhere else. And Washington, DC, both Level I trauma centers surveyed, they are over capacity and treating patients in hallways and waiting rooms.

So if in the middle of this inadequate capability of our emergency rooms to deal with ordinary problems we had a terrorist attack, I just think that if we go ahead with the billions of cuts in Medicaid funds for those institutions, we are making the problem worse. The first thing at the Federal level is at least not do any harm. I think a lot of people can ask how is it possible that 6 years since 9/11, nearly 3 years after Hurricane Katrina, we have spent billions of taxpayer dollars on homeland security, and yet our emergency systems are not in place?

I don't doubt that you have very good intentions and a lot of helpful initiatives, but the problem is that the positive effect of these programs, which involve grants of millions of dollars, are going to be overwhelmed when we pull out billions of dollars in some of these Medicaid cuts.

We were told Monday that the Medicaid regulations will cripple hospital emergency rooms. The head of Virginia's emergency response program said you take away significant Medicaid funding, it is going to be disastrous. An expert from UCLA said the regulations would cripple emergency care in Los Angeles.

Secretary Leavitt, do you think these experts are wrong?

Secretary LEAVITT. Mr. Chairman, I think we are dealing with two fundamentally different assumptions. They are fundamentally different assumptions in two areas. The first is the way surge capacity works, and that we would have to rely on hospitals as the bed for surge capacity. The second is that the mission of Medicaid is the assurance of emergency preparedness.

Let me deal with the first one, surge capacity and the way it works.

Chairman WAXMAN. I am asking about the Medicaid, the Medicaid cuts by these new regulations. I know we contacted you and your Department, and we asked for every document that you might have that would indicate that you—if you did an analysis to find out what the impact would be of these Medicaid regulations. And I think we might have even sent the same request to the Department of Homeland Security. And we found that there was not a single analysis of the effects of the Medicaid regulations on our Nation's emergency rooms. If that is the case—maybe we haven't received it, but if that is the case, no analysis has been done. I just think that is irresponsible.

Secretary LEAVITT. Mr. Chairman, we have exercises on a regular basis, and the people from CMS sit at the same table as those from our Assistant Secretary for Preparedness and Response. Medicaid's mission, however, is not emergency preparedness; it is to provide health care to people, not to support institutions. Now, at HHS we have a very important Assistant Secretary for Preparedness and Response who is tasked with that responsibility. We have made substantial investments in developing surge capacity.

Chairman WAXMAN. Did he do an analysis of what the impact would be of the Medicaid regulations that withdraw money from these institutions?

Secretary LEAVITT. He manages emergency response, not Medicaid. The analysis on Medicaid was based on the fact that the funds were being drawn for purposes that we believe were inappropriate under the mission of Medicaid, which we believe to be helping people, not supporting institutions.

Chairman WAXMAN. Well, they help people by supporting institutions. Our public hospitals are absolutely dependent on the Medicaid dollars. They have so many people that come into emergency rooms that have no insurance, and the hospitals then have to shift the cost. And then if they find that Medicaid is not going to pay them for graduate medical education or other functions that they serve, they just have to give up the expensive things like Level I trauma centers. That is what they are telling us. But it looks like they never told you because they were never asked the question of what the impact would be with these Medicaid cuts.

Secretary LEAVITT. Mr. Chairman, it probably won't surprise you that I hear similar expression from those who run schools, who say, we need to have more money for our schools, and if we can find a way to get Medicaid money to support our school effort, it will help our schools. I hear a similar thing from those who run child welfare programs; if we could just get some Medicaid money, it would help us, and they stretch it over to health care. Medicaid was not intended to be our emergency response mechanism.

Chairman WAXMAN. It wasn't intended, but, in fact, it is.

Secretary Chertoff, you are head of the Homeland Security. You have designated this issue of health care functioning to HHS, and yet they are saying that they don't know what the impact is going to be of these cuts.

Congress always holds hearings after the fact. After Hurricane Katrina and that disaster, we held hearings, and we asked, how

could this happen? This is a hearing to find out if we are prepared. I don't want it on my conscience years after a terrorist attack, God forbid, that we realize that we didn't do what was necessary because the bureaucracies weren't functioning the way they should, the planning wasn't taking place, that there was money being withdrawn so that the whole system, which is all very fragile in this country for health care, wasn't able to function when it came to emergency care or preparedness for a surge of victims of a terrorist attack. I don't want it on my conscience.

Do you feel that you can tell us today that your conscience would say that we are doing all that we need to do, Secretary Leavitt and Secretary Chertoff?

Secretary LEAVITT. Mr. Chairman, I share with you the worry about surge capacity. It is a responsibility that I have and we have at HHS. I also worry about the long-term sustainability of Medicaid. Medicaid was not designed nor intended to be the source of money that we use to design an effective surge capacity strategy in this country. We do have a means by which that should be done. If Congress in its wisdom believes that more money is needed for more surge capacity, we need to use the intended vehicle. We need to apply it to a logical, thoughtful strategy. That logical and thoughtful strategy will not include emergency rooms being the only place where surge capacity takes place. There is not an emergency room in America that you can't build a scenario for that will blow the doors off in a very short period of time.

Chairman WAXMAN. So you feel good about the situation?

Secretary LEAVITT. No, that is not what I said at all, Mr. Chairman. I said I don't feel good about the situation, but I don't believe Medicaid is the way to solve it.

Chairman WAXMAN. And you think we ought to give other money, but we haven't been asked to give other money for this purpose.

Secretary Chertoff, how do you feel?

Secretary CHERTOFF. I actually agree with Secretary Leavitt on this. I think that I am the last person to tell you I think we are done. I think that we are—and I have been involved in more specifically looking at the issue of emergency response in the Gulf States. But more generally I think we need to be identifying gaps based on planning done at a Federal, State and local level. And then if we need to plug the gaps with money, the money ought to be targeted to plug the gaps.

Where I am seeing a bit of a disconnect, I have no reason to believe that giving more Medicaid money to hospitals is going to result in that money being spent specifically on those items which would be required to deal with a surge situation. Nor is it obvious to me that the only solution in this surge situation is the emergency rooms.

So the question to me would be do they need to have additional beds in storage? Do they need to have additional ventilators or medication or things of that sort? And if, in fact, there is a gap, that ought to be directly funded, but with the understanding that money is going to be spent on those issues. I have no reason to believe that Medicaid funding in a hospital is necessarily going to be dedicated to emergency response as opposed to something else.

Chairman WAXMAN. A lot of it is being dedicated to this now, and that money is going to be withdrawn, and it is a sizable amount of money.

I have taken up 13 minutes, and I am going to give 13 minutes to Mr. Davis.

Mr. DAVIS OF VIRGINIA. Thank you, Mr. Chairman.

Secretary Leavitt, let me start with you. Thanks for being here. Regardless of one's views on the regulation, I am concerned about using Medicaid reimbursement to support emergency medical preparedness because it is an imperfect financial tool. In my experience, hospitals use additional revenues created through reimbursement policy. They can be reinvested in ways that may not improve emergency capacity, as Secretary Chertoff just noted. For example, hospitals may more regularly reinvest in expanding capacity for profitable services, orthopedics for example.

Do you think that additional Medicaid reimbursement necessarily results in improved emergency surge capacity?

Secretary LEAVITT. There is no evidence that it does.

Mr. DAVIS OF VIRGINIA. Thank you very much.

I mean, Medicaid is the fastest-growing part of the Federal budget. It is the fastest-growing part of States' budgets as well. And to allow this to continue without tampering and looking at ways that we can improve service, but at the same time cut back costs means there won't be money for a lot of other things in the budget downstream.

Let me ask you this, Secretary Leavitt. For the Homeland Security Presidential Directive No. 21, it is my understanding that there is a stakeholder group that is working on the different financial levers available to improve preparedness. The group is looking at Medicare, Medicaid, private payer, grant funding and market forces. How does this group's work inform future funding decisions made at the Department?

Secretary LEAVITT. That group is looking at that question as well as many, many others to form this question. Until I receive their report, I don't know what they will say. I think it is clear that homeland security is everyone's second job. We all have a primary job. The job of Medicaid is to take care of people who are poor or indigent or disabled, and States are using ambiguities in the law to try and tap that fund for many different reasons.

Mr. DAVIS OF VIRGINIA. Because it is the largest part of their budget?

Secretary LEAVITT. And they have determined——

Mr. DAVIS OF VIRGINIA. Even in economic downturns when their revenues are less, the Medicaid costs are going up.

Secretary LEAVITT. In fact, Mr. Davis, I would make the point that Medicaid is the single greatest influence on State budgets right now.

Mr. DAVIS OF VIRGINIA. I agree.

Secretary LEAVITT. And if you wanted to see why States were not investing and why they were looking for ways in which they could divert Federal funds into schools and to child welfare and to public health and public safety, it is because Medicaid is pushing all those things out and crowding them out. Their capacity to do that is being compromised by the fact that the program is growing so fast.

Mr. DAVIS OF VIRGINIA. And understand this, 10, 12 years ago it was really not a factor in State governments the way it is today.

Secretary LEAVITT. I was elected Governor in 1993, and I would have to check this, but I believe it was in the neighborhood of 6 percent of the State budget. Today, again, I would have to check, but I am guessing it is like every other State in that it is close to 20 percent. That means every one of those dollars is crowding out education, it is crowding out higher education, it is crowding out public response and preparedness, all of the things we are talking about.

Mr. DAVIS OF VIRGINIA. So in point of fact, putting more money into this may have the opposite effect?

Secretary LEAVITT. Well, it has had the opposite effect.

Mr. DAVIS OF VIRGINIA. The Homeland Security Presidential Directive No. 21 requires that the group review financial incentives that improve preparedness without increasing health care costs. There are economic reasons that hospitals have not increased emergency department capacity or the number of inpatient beds. How does the health system increase capacity without increasing costs?

Secretary LEAVITT. Well, I want to emphasize in this process the whole concept of all—of being—of all perils response. Everything we do to prepare, for example, for a pandemic helps us for a bioterrorism event. Anything we can do that will use the same assets for multiple things allows us to expand capacity without expanding costs. The idea of sharing assets.

The way our surge capacity is designed to work, we know that there is a scenario for every hospital, no matter how big, no matter how well funded, no matter how sophisticated, that the capacity will exceed their ability to deal with that. And therefore every hospital and every community needs to have a surge capacity plan that allows them to use schools that may, in fact, have been mothballed. Or I have seen plans where shopping centers are converted into surge capacity. I have actually witnessed during Katrina convention centers being turned into hospitals, and very good hospitals, in the context of 24 hours.

So surge capacity is about using existing assets to convert to hospital capacity very quickly. It is not simply using the emergency room. If you were to look at any emergency room in this country, you would see that at least half of what is there at any given moment would not be considered absolutely critical. And if we turn into an emergency, those will be moved away or asked to be deferred, and we will have substantial capacity that would not have been evident in the snapshot that was taken that the chairman referred to.

Mr. DAVIS OF VIRGINIA. Thank you.

I would like to ask unanimous consent that a Wall Street Journal article, Nonprofit Hospitals Once for the Poor Strike It Rich, be included in the hearing record.

Chairman WAXMAN. Without objection.

[The information referred to follows:]

THE WALL STREET JOURNAL. ONLINE

April 4, 2008

PAGE ONE

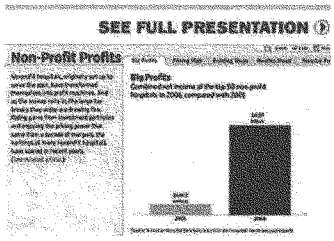
Nonprofit Hospitals, Once For the Poor, Strike It Rich

With Tax Breaks, They Outperform For-Profit Rivals

By JOHN CARREYROU and BARBARA MARTINEZ
April 4, 2008; Page A1

Nonprofit hospitals, originally set up to serve the poor, have transformed themselves into profit machines. And as the money rolls in, the large tax breaks they receive are drawing fire.

Riding gains from investment portfolios and enjoying the pricing power that came from a decade of mergers, many nonprofit hospitals have seen earnings soar in recent years. The combined net income of the 50 largest nonprofit hospitals jumped nearly eight-fold to $4.27 billion between 2001 and 2006, according to a Wall Street Journal analysis of data from the American Hospital Directory. AHD, an information-service company, compiles data that hospitals report to the federal government.



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The Cleveland Clinic swung from a loss to net income of $229 million during that period. No fewer than 25 nonprofit hospitals or hospital systems now earn more than $250 million a year. One nonprofit hospital system, Ascension Health, has a treasure chest of $7.4 billion -- more than many large, publicly traded companies.

Nonprofits, which account for a majority of U.S. hospitals, are faring even better than their for-profit counterparts: 77% of the 2,033 U.S. nonprofit hospitals are in the black, while just 61% of for-profit hospitals are profitable, according to the AHD data.

At some nonprofits, the good times are reflected in new facilities and rich executive pay. Flush with cash, Northwestern Memorial Hospital in Chicago has rebuilt its entire campus since 1999 at a cost of more than $1 billion. In October, it opened a new women's hospital that features marble in the lobby, birthing rooms with flat-screen televisions, 1,000 works of art and a roof topped with 10,000 square feet of gardens. In 2006, Northwestern Memorial's former chief executive officer, Gary Mecklenburg, received a $16.4 million payout.

But Northwestern Memorial has been frugal in its spending on charity care, the free treatment for poor patients that nonprofit hospitals are expected to provide in return for the federal and state tax breaks they receive. In 2006, Northwestern Memorial spent $20.8 million on charity care -- less than 2% of its revenues and a fraction of what it received in tax breaks. By comparison, the hospitals run by Cook County, where Northwestern Memorial is located, spent 14% of revenues on charity care.

WSJ's John Carreyrou provides a tour of Chicago's non-profit Northwestern Memorial Hospital, which underwent a renovation costing more than $1 billion.

Northwestern Memorial says that in addition to charity care, it provides other benefits to its community, such as pioneering research in obstetrics and other areas that improve standards of care nationally.

To be sure, some nonprofit hospitals, particularly ones in inner cities that handle large numbers of uninsured patients, remain under financial strain and are struggling to keep their doors open.

But the growing gap between many nonprofit hospitals' wealth and what they give back to their communities is raising questions about the billions of dollars in tax exemptions they receive.

BACKSTORY

• Read more about how[2] nonprofit hospitals went from charity and tax breaks to healthy profits.

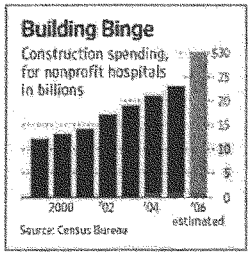
"Some nonprofit hospitals seem to forget that their operations are subsidized with generous tax breaks. They allow their priorities to get out of whack," says Sen. Charles Grassley. The senior Republican on the Senate Finance Committee threatened last year to introduce legislation forcing nonprofit hospitals to provide a minimum amount of charity care.

Nonprofit hospitals account for about 60% of the more than 3,400 hospitals in the U.S. The rest are either for-profit or government-owned.

In a report issued in December 2006, the Congressional Budget Office estimated nonprofit hospitals receive $12.6 billion in annual tax exemptions, on top of the $32 billion in federal, state and local subsidies the hospital industry as a whole receives each year.

Community Benefit

In return for not paying taxes, nonprofit hospitals are supposed to provide a "community benefit," a loosely defined requirement whose most important component is charity care. But many hospitals include other expenses in their community-benefit accounting to the Internal Revenue Service, including unpaid patient bills. Often, hospitals also include the difference between the list prices of treatment they provide and what they are paid by Medicaid and Medicare, the government programs for the poor, disabled and elderly. Excluding those other expenses, many hospitals spend less on charity care than they get in tax breaks, studies by various counties and states show.



One nonprofit hospital system, St. Louis-based BJC HealthCare, counts the salaries of its employees as a community benefit. BJC, which runs 14 hospitals in Missouri and Illinois, says on its Web site that it provided more than $1.8 billion in benefits to various communities in 2004. Its payroll, including its CEO's $1.8 million compensation, accounted for $937 million of that figure, while charity care represented $35 million, according to BJC.

"The impact that any organization that's job-producing and buying goods has on a community is of benefit to that community," says BJC HealthCare spokeswoman June Fowler. However, she says BJC won't count its payroll as a community benefit in the future because of new standards adopted by the IRS.

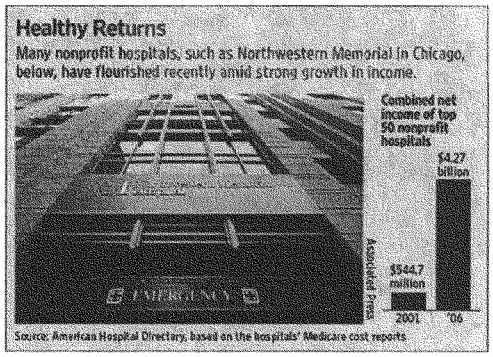
The new standards, due to take full effect in 2009, will require nonprofit hospitals to break out specifics of their community-benefit contributions. But they won't require the hospitals to provide any minimum amount of charity care.

The size of nonprofit hospitals' tax exemptions is coming under scrutiny in part because their incomes have risen so sharply in recent years, and because they represent such a big chunk of America's health-care spending. Thirty-one cents of every dollar spent on medical care is spent on hospitals.

One reason for hospitals' soaring profits is a gradual increase in Medicare

reimbursements after federal budget cutbacks during the 1990s. By merging and gaining scale, many hospitals also gained leverage in price negotiations with health insurers.

However, much of the industry's profit growth comes from strategies it honed to increase profits. Among them: demanding upfront payments from patients; hiking list prices for procedures and services to several times their actual cost; selling patients' debts to collection companies; focusing on expensive procedures; and issuing tax-exempt bonds and investing the proceeds in higher-yielding securities.



Untaxed investment gains have greatly increased some hospitals' cash piles. Ascension Health, a Catholic nonprofit system that runs 65 hospitals, mostly in the Midwest and Northeast, reported net income of $1.2 billion in its fiscal year ended June 30, 2007, and cash and investments of $7.4 billion. That's more cash than Walt Disney Co. has.

Ascension says it needs to maintain a sufficient amount of cash to pay for charity care, to keep the interest rates it pays on its debt low, to provide retirement benefits to its 106,000 employees, and to make capital and technology investments at its hospitals.

At the University of Pittsburgh Medical Center, which runs 20 facilities, cash and investments totaled $3.35 billion at the end of last year. UPMC says the money goes toward producing "world-class health care, education and research," citing the $1 billion it spent over five years to create electronic medical records for patients and an additional $500 million to build a children's hospital and a network of cancer centers.

But some of UPMC's expenses are only tenuously related to medicine. In its 2006 fiscal year, UPMC also spent $10 million on advertising, including $1 million on ads in the New York Times. Wendy Zellner, a spokeswoman for the hospital, says the ads enable UPMC "to better compete with other leading hospitals."

UPMC paid its CEO, Jeffrey Romoff, $3.3 million in fiscal 2006. Mr. Romoff also received $36,995 from the hospital to cover a car allowance, spousal travel and

legal and financial counseling. Ms. Zellner says what UPMC pays Mr. Romoff is in line with "nonprofit and for-profit organizations of comparable scope and complexity."

Some nonprofit hospital executives enjoy other perks. Royal Oak, Mich.-based Beaumont Hospitals says it paid $10,795 for the country-club membership of the president of its foundation last year. A spokeswoman for Beaumont says it pays for the membership to provide the executive "a venue with access to potential donors."

The Cleveland Clinic continued to pay its former CEO, Floyd Loop, more than $1 million a year for two years after he retired in April 2005. The Cleveland Clinic says part of that was deferred compensation and vacation pay and the rest was for consulting services.

Hospitable Pay

Some of the best paid nonprofit hospital CEOs

CEO	Hospital	Total accrued compensation, in millions	Year
Gary Mecklenburg*	Northwestern Memorial Hospital	$16.4	2006
Floyd Loop†	Cleveland Clinic	7.5	2006
Mark Neaman	Evanston Northwestern Healthcare	5.4	2006
Lloyd Dean	Catholic Healthcare West	5.3	2006
Philip Incarnati	McLaren Health Care Corp.	5.2	2006
Joseph Trunfio	AHS Hospital Corp.	5.0	2005
Alan Brass	ProMedica	4.1	2005
Herbert Pardes	New York-Presbyterian	3.5	2006
Jeffrey Romoff	UPMC	3.3	2006
Douglas French‡	Ascension Health	3.3	2004

*Retired on Sept. 1, 2006; total includes a retirement payout and deferred compensation †Retired in April 2005; $6.4 million of the $7.5 million is a split-dollar life insurance policy, the rest is deferred compensation, vacation pay and consulting fees ‡Resigned in May 2004

Sources: Forms 990 filed to the IRS; the hospitals

The University of California San Francisco Medical Center provided its CEO and chief operating officer low-interest mortgage loans of more than $1 million each, according to the University of California's executive compensation reports. A UCSF spokeswoman says such loans help recruit and retain executives, given the area's high cost of housing.

Catholic Healthcare West, a hospital system based in San Francisco, forgave a $782,541 housing loan it made to its CEO, Lloyd Dean. Counting the forgiven loan, Mr. Dean's total accrued compensation in 2005 was $5.8 million. Catholic Healthcare West says his compensation reflects his skill in turning the hospital system around financially.

One nonprofit hospital executive who has benefited from the industry's good fortunes is Mr. Mecklenburg, the former CEO of Chicago's Northwestern Memorial. The hospital says it paid him $5.45 million in salary, bonus and deferred compensation in its fiscal year ended Aug. 31, 2006, and an additional $10.95 million when he retired the next day. The hospital also awarded five other executives a combined $13.3 million in total compensation in fiscal 2006, according to its filings to the IRS.

Mr. Mecklenburg, now a partner at Chicago private-equity firm Waud Capital Partners LLC, declined to comment, referring questions to the hospital and to the former chairman of its compensation committee, James Denny.

Stellar Results

Northwestern Memorial says a big part of Mr. Mecklenburg's $16.4 million payout represents retirement benefits and deferred compensation accrued over his 21-year tenure. Mr. Denny, who chaired the hospital's compensation committee from 1995 to January 2008, says Mr. Mecklenburg delivered stellar results, nearly quintupling the hospital's patient revenues. "Our view of it is: This is the best deal we've ever made," he says.

Critics argue that Mr. Mecklenburg's compensation is excessive for a charity organization that gets tens of millions of dollars a year in tax breaks. Northwestern Memorial sits on property on the Gold Coast, Chicago's most affluent neighborhood, abutting Lake Michigan. The Center for Tax and Budget Accountability, a Chicago nonprofit organization, estimates the value of the hospital's annual property-tax exemption at $37.5 million. Northwestern Memorial is also exempt from $12.5 million in sales tax for a total of $50 million in annual tax exemptions, not counting the taxes it doesn't pay on its investment gains, the center estimates.

"The hospital's tax benefit is more than two times greater than the charity care provided," says Heather O'Donnell, the center's health-care policy director.

Northwestern Memorial says it hasn't calculated the value of its tax exemptions. Robert Christie, the hospital's vice president for government relations, notes that the Center for Tax and Budget Accountability receives funding from the Service Employees International Union, which represents numerous hospital employees and frequently clashes with hospitals in labor disputes. Ms. O'Donnell says her organization receives funding from many foundations besides SEIU.

Peter McCanna, Northwestern Memorial's chief financial officer, says the hospital's contribution to its community should be judged more broadly. "We fundamentally disagree with narrowing [the definition of] our community-benefit contribution to charity care," he says. He says Northwestern Memorial's research and education expenses should also be counted. The hospital is the primary teaching hospital for Northwestern University's Feinberg School of Medicine.

Taking into account educational and other expenses, such as bad debt and unreimbursed Medicaid costs, Northwestern Memorial values its total community-benefit contribution at $230 million for fiscal 2006.

Room Service

Around Chicago, Northwestern Memorial is known as a hospital that attracts the well-heeled. It's a short walk from the Magnificent Mile, the famous thoroughfare lined with expensive shops and restaurants. At Northwestern Memorial's new Prentice Women's Hospital, expectant mothers can watch TV or browse the Internet on 42-inch flat-screen televisions, order room service 24 hours a day and page nurses and doctors via a wireless system. Some birthing rooms have views of Lake Michigan. Only 6% of Northwestern Memorial's patient revenues come from Medicaid.

By comparison, Sacred Heart Hospital, a small for-profit hospital in a poor neighborhood on the west side of the city, gets 62% of its revenues from Medicaid and pays several million dollars a year in taxes, according to its president, Edward Novak. Parts of Sacred Heart date back to 1928, when the hospital was founded. Another wing was built in 1950. Mr. Novak says he would like to replace the aging hospital with a new facility, but is struggling to figure out how to pay for it. He says his compensation is less than $220,000 a year.

At John H. Stroger Jr. Hospital -- formerly known as Cook County Hospital -- 56% of patients don't have any insurance when they are admitted, says John Cookinham, the hospital's chief financial officer. At Northwestern Memorial, the percentage of uninsured patients is less than 5%. Stroger's chief operating officer earned $204,485 in 2007, according to Cook County budget records.

In recent years, some nonprofit hospitals have decided to stop using the courts to collect from patients who owe them money. But Northwestern Memorial pursues patients such as Iris Ayala who haven't paid their bills. While running an errand for her employer, the 50-year-old Ms. Ayala fainted and collapsed in the street one day in 2006. A friend rushed her to Northwestern Memorial's emergency room.

Ms. Ayala says her insurer paid for the bulk of her 24-hour hospital stay, but she was responsible for a $1,035.39 co-pay. Working only part-time because of health issues and with a daughter in college, she says she couldn't afford her portion of the bill.

After representatives for Northwestern Memorial repeatedly called her to ask for payment, Ms. Ayala says she promised she would settle the bill once she got her annual tax refund. But Northwestern Memorial sued her in Cook County Circuit Court in July 2007. To make the lawsuit go away, Ms. Ayala says she borrowed the money and paid the hospital. "They didn't want to hear my sob story," she says.

Northwestern Memorial declined to discuss Ms. Ayala's case, citing patient privacy laws. Mr. McCanna says the hospital sued only 82 patients in 2006 and 2007, a number he says is small compared with the more than one million accounts it billed over that period. He says the hospital tries to determine whether patients who are

behind on bills qualify for assistance, but some can't be reached or refuse to volunteer information about their finances. "Absent of information, a lawsuit is sometimes the only recourse," he says. Mr. McCanna adds that, in some cases, the hospital has waived patients' bills after later learning that they did qualify for aid.

Northwestern Memorial says its strong balance sheet allows it to provide outstanding care and conduct innovative research. As of Aug. 31, 2007, its cash and investments totaled $1.82 billion, making it one of richest individual nonprofit hospitals in the country. With such a treasure chest, it could operate for a year and two months without any revenue -- a gauge of financial strength Mr. McCanna highlights in presentations to bond investors and analysts.

"Nonprofit is a misnomer -- it's nontaxable," says Sacred Heart Hospital's Mr. Novak. "When you're making hundreds of millions of dollars a year, how can you call yourself a not-for-profit?"

Write to John Carreyrou at john.carreyrou@wsj.com[3] and Barbara Martinez at Barbara.Martinez@wsj.com[4]

Mr. DAVIS OF VIRGINIA. Thank you.

The majority staff report on the status of emergency departments looked at 34 hospitals and found that many were operating at or above capacity. Three hospitals were diverting ambulances, including one hospital that is undergoing a major expansion that includes the recent purchase of 3 million pounds of travertine imported from Tivoli, Italy, and 569 flat-panel TVs. Another hospital that, according to the majority report, had patients in overflow spaces and borders has also undergone a significant expansion that included a new women's hospital with marble in the lobby, and flat-screen TVs, and birthing rooms. Both of these hospitals are nonprofits and appears that they have sufficient resources to invest in marble and TVs, but not enough to invest in emergency departments.

Is this typical, and is this appropriate in your view?

Secretary LEAVITT. Well, it is not appropriate, in my mind. I don't know how typical it is. I think the point you are making is a good one, and that is many times the lack of emergency room capacity is because the administration of the hospital has chosen not to invest there because it didn't, in fact, assist their business model.

Mr. DAVIS OF VIRGINIA. And, in fact, by raising Medicare reimbursement and diverting that money to pay for marble floors and flat-screen televisions really doesn't go anywhere to solve this problem, does it?

Secretary LEAVITT. You made the point earlier that there is no assuredness or no guarantee that money coming from Medicaid would going into emergency preparedness, and there is no direct link.

Mr. DAVIS OF VIRGINIA. The question is if we want to look at surge capacity, perhaps Medicaid is not the best way to look at that.

Secretary LEAVITT. Indeed, Mr. Davis, it is not. I want to emphasize I believe that there are deficiencies in our surge capacity. I just don't believe Medicaid dollars is the source of funds that ought to be directed or looked to to link to that solution.

Mr. DAVIS OF VIRGINIA. Thank you.

Secretary Chertoff, thanks for being with us today. Does DHS have the expertise to determine the appropriateness of any of the following matters as it relates to Medicaid? Let me go through them. Whether public providers should be limited to cost in Medicaid reimbursement.

Secretary CHERTOFF. No, we rely on HHS. Frankly, the whole issue of Medicaid is not actually within our purview. So the short answer is no, we don't have the expertise.

Mr. DAVIS OF VIRGINIA. Do you have the expertise to determine the appropriateness of the definition of unitive government for health providers that treat Medicaid patients?

Secretary CHERTOFF. No.

Mr. DAVIS OF VIRGINIA. How about the appropriateness of graduate medical education payments in Medicaid?

Secretary CHERTOFF. No.

Mr. DAVIS OF VIRGINIA. How about the scope of rehabilitation services?

Secretary CHERTOFF. No.

Mr. DAVIS OF VIRGINIA. How about the appropriateness of the administrative claims for schools?

Secretary CHERTOFF. No.

Mr. DAVIS OF VIRGINIA. The definition of the scope of outpatient services?

Secretary CHERTOFF. No.

Mr. DAVIS OF VIRGINIA. The definition of the scope of targeted case management services.

Secretary CHERTOFF. No.

Mr. DAVIS OF VIRGINIA. Thank you.

The National Response Framework encompasses a broad array of functions and entities.

Secretary CHERTOFF. Correct.

Mr. DAVIS OF VIRGINIA. For example, transportation, communication, roads, utility and public work infrastructure may all be heavily used in an emergency; however, these facilities also have important functions unrelated to disaster response or homeland security. Therefore it seems imprudent to describe any service that might have a role in an emergency as a homeland security activity.

How do you determine what functions are primarily related to homeland disaster compared to those that are tangentially related?

Secretary CHERTOFF. Well, I agree with you. The key philosophy is what is directly related, and the way we go about that is we put together a plan. We analyze what are the core capabilities that we have to have to respond effectively. We then identify and survey whether there are gaps in those capabilities, and then we determine what is the best way to plug those gaps.

Mr. DAVIS OF VIRGINIA. Thank you.

Mr. Shays.

Mr. SHAYS. Thank you both for being here, and thank you, Mr. Chairman, for having this hearing.

I am wrestling with the fact that I think we are really dealing with two issues. We are dealing with the health care issues and the needs of our hospitals, and we are dealing with a potential catastrophic event and a surge capacity. I would like to know from each of you who has the responsibility? First, has there been a study done that looks at the entire United States to say how many Trauma I, Trauma II and Trauma III centers we need and ideally where they should be located?

Secretary LEAVITT. Mr. Shays, with respect to emergencies, we are currently doing a study right now under the matter that was referred to earlier.

Mr. SHAYS. Can you move the mic a little closer?

Secretary LEAVITT. Yes. We are currently doing a study under HSPD–21, the group that was referred to earlier. However, I can also tell you that we are asking and requiring grantees of HHS for pandemic preparedness to give us information about their surge capacity plan. Between those two, we will have a very good idea in the future as to what the capacity is and where our gaps are.

I would also like to make the point——

Mr. SHAYS. When do you think that would be done?

Secretary LEAVITT. We expect it to be done by the end of this year so that we can make the report before the end—conclusion of this term.

But I would like you to know that we already have the capacity at any given moment to determine where rooms and beds are available anywhere in the country within a reasonably short period of time. During Katrina I was constantly updated as to how many beds we had anywhere in a region that we could move patients to. This is an important part of the way surge capacity works. We are discussing surge capacity today as to what you can put into an emergency room at any given hour. That is not the way surge capacity works.

Mr. SHAYS. I want to make sure that my colleague has time. I would like a brief comment from both of you as to who is ultimately responsible for this issue, because it seems to me like when two people are, no one is.

Secretary LEAVITT. I think we both agree HHS has responsibility for any matter related to medical response in a disaster.

Mr. SHAYS. And so it would be your job, not DHS, to determine how many Trauma I, II and III units we need around the country.

Secretary LEAVITT. Well, it will be our determination to determine how many we have, what our gap is and how best to respond to that.

Mr. SHAYS. Thank you.

Mr. ISSA. Thank you.

Governor, I will continue along that line. With 259 trauma centers in the country, 5 in San Diego, 4 in Utah, it is very clear that in San Diego we have as much capacity for our 2 million people in a relatively small area as Utah has in a huge area. For all practical purposes, in the case of disasters of any sort, take the Northridge earthquake, aren't we essentially always assuming for homeland security that they are going to be in high-risk areas, where ultimately the people of Utah or Oklahoma or Wyoming could just as easily have a huge disaster affecting thousands of people over an area that could not possibly concentrate the types of hospitals that we have in Los Angeles or San Diego? So ultimately isn't the planning for major disasters more about the essential planning and training and ability to move people than it ever will be about having operational extra spaces in one location?

Secretary LEAVITT. Yes. There is no one area of the country capable of handling their own surge in an event of sufficient size to require that kind of capacity.

Chairman WAXMAN. Mr. Davis, your time has expired.

Ms. McCollum.

Ms. MCCOLLUM. Mr. Chairman, the report conducted by the committee highlights serious challenges confronting hospital emergency rooms, and crowding is a serious problem. The American College of Emergency Physicians released a report last month that addresses the crowding issue. The report asks what causes crowding, and it responds, "Over the years the reasons for crowding have included seasonal illnesses, visits by the poor and the uninsured who have nowhere else to turn except the safety net provided by emergency departments. This country can continue to expand the capacity of emergency rooms, to serve as a provider of last resort for the uninsured and the mentally ill, or Congress can work to provide universal health care for all Americans. The choice is ours."

Mr. Chairman, I don't know about the situation in New York, Washington, Chicago, Houston, Denver or Los Angeles. I have never visited an emergency in any of those cities, so I will take this report's findings as accurate. But I live in Minnesota, and I need to set the record straight.

First, the report inaccurately states that Minneapolis is hosting the 2008 Republican Convention. The convention will take place in St. Paul, MN, my congressional district, with Minneapolis accommodating many of the visitors. This distinction is important, especially for the St. Paul officials, first responders, health care professionals involved in preparing to meet the needs of 40,000 visitors, including the President of the United States and Republican nominee for President.

Second, the report examines Hennepin County Medical Center, which is an excellent hospital and a Level I trauma center located in Minneapolis. In the event of an emergency at the national Republican convention, Regions Hospital in St. Paul, an excellent facility, will be the primary responder, with the hospital examined in the report providing support.

What concerns me about this report is it examines Minneapolis solely as the presence of the national convention, yet it evaluates emergency room capacity on a random day, March 25, 2008. During the 4 days in September when the Republicans gather in St. Paul, there will be significant additional resources available to ensure a safe, enjoyable convention. There will also be an emergency plan and considerable assets in place to respond to any foreseen event.

The Department of Homeland Security designated the national party conventions as a national special security event. This Congress appropriated $50 million to each host city to ensure coordination is seamless between Homeland Security, Secret Service, local and State law enforcement and their first responders.

Finally, while I fully understand the use of Madrid terrorist attacks as a standard for assessing casualty preparedness, real American tragedies like the Oklahoma City bombing, Hurricane Katrina, Virginia Tech shooting could also have been used as models.

In the Twin Cities we don't need to investigate emergency room capacity using a telephone survey. Our first responders were forced to respond to an emergency in real time. Only 9 months ago on August 1, 2007, at 6:05 during rush hour, 8 lanes of traffic on Interstate 35W, the bridge, it collapsed into the Mississippi River. That night 13 people died, many my constituents. And more that 110 patients required emergency and medical attention. The bridge collapsed due to structural failure. It just as easily could have been the result of a terrorist attack, but the disaster tested the very hospital in the committee's report.

Hennepin County Medical Center and hospitals from the entire Twin Cities metropolitan area responded heroically, professionally and efficiently. Their response was not a simulation or a blind phone survey, it was real. And people are alive today because of that response.

Mr. Chairman, I have statements from Hennepin County Medical Center, Regions Medical Center, St. Paul's chief of police, Min-

nesota Hospital Association, I would like to have the committee's permission to enter these into the committee report.

Chairman WAXMAN. Without objection, that will be the order.

[The information referred to follows:]

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John M. Harrington, Chief of Police

CITY OF SAINT PAUL
Christopher B. Coleman, Mayor

367 Grove Street
St. Paul, Minnesota 55101

Telephone: 651-291-1111
Facsimile: 651-266-5711

May 6, 2008

Congresswoman Betty McCollum
1714 Longworth Bldg.
Washington D.C. 20515

Dear Congresswoman McCollum:

Thank you for providing me with an opportunity to respond to the City of Saint Paul's emergency preparedness leading up to the 2008 Republican National Convention in Saint Paul, Minnesota.

I would like to clarify for the Committee that while both the cities of Minneapolis and Saint Paul are hosts to the Republican National Convention from September 1 through September 4, the convention will take place in the Xcel Energy Center, located in downtown Saint Paul, Minnesota. The Saint Paul Police Department (SPPD) is the lead local agency in charge of security planning.

I recently became aware of a survey of level 1 trauma centers around the country. I found it more than a little disconcerting to find that the level 1 trauma center at the epicenter of this year's Republican National Convention was not one of those mentioned and, apparently, not evaluated.

One of the selection criteria that caused the City of Saint Paul to rise to the top was Regions hospital and its excellent trauma center along with an outstanding paramedic service provided by the City. As an example I would cite the recently published US Fire Administration Technical Report on the I-35W Bridge collapse response (USFA, 2008), Emergency Management was highlighted as one of the strengths of the successful response. Regions hospital and Saint Paul Fire Paramedics was a part of that response. Regions Hospital has been a close partner to the SPPD and the USSS in emergency preparedness in general and convention security planning in particular. In fact, the Regions Hospital EMS Medical Director, R.J. Frascone, has been a member of our planning subcommittees from the very beginning.

Thank you again for the opportunity to address this oversight.

Sincerely,

John M. Harrington
CHIEF OF POLICE

Statement from Bruce Rueben, President
Minnesota Hospital Association
May 6, 2008

"Minnesota hospitals are ready. Whether natural disaster or man-made emergency, hospitals have equipment and plans in place to best handle the unexpected. In the Twin Cities, hospitals have developed a coordinated response, working together to share resources and provide care.

While hospitals can't predict the scope and scale of a disaster, they can have thorough preparedness plans in place. Our plans were tested last August when the Interstate 35W bridge in Minneapolis collapsed into the Mississippi River. Hospitals were ready, treating more than 110 patients at twelve different hospitals across the city. National leaders praised Minnesota's quick and efficient response where patients were triaged at the scene and sent to the appropriate level of emergency department care."

Regions Hospital response to surge capacity snapshot

Regions Hospital in St. Paul, Minn., is a 427-bed, Level I Trauma Center and teaching hospital that has served Minnesota and western Wisconsin for more than 130 years. As a Level I Trauma Center, Regions is equipped to handle the most complex injuries and illnesses. Regions also has a burn center, verified as a regional burn center by the American Burn Association through the American College of Surgeons.

Regions trauma and emergency departments work closely with the hospital's Emergency Medical Services program. Regions also houses the East Metro Medical Resource Control Center (MRCC), which coordinates the care and transportation of patients in the area so that those with critical conditions receive the treatment they need from a hospital with the capacity to best serve them. In addition, Regions works in close collaboration with other hospitals in the Twin Cities, including the other Level I Trauma Centers: Hennepin County Medical Center and North Memorial Medical Center.

While Regions is prepared to care for the injured in the event of a Mass Casualty Incident (MCI), hospitals such as Regions serve as the safety net for a disproportionate number of uninsured and Medicaid patients. It is unrealistic to expect that these hospitals will be able to continue to respond effectively, as well as provide care for the uninsured/underinsured, should further cuts to the Medicaid program be made. Some hospitals across the nation have been forced to close their Level I Trauma Centers because of lack of reimbursement, which weakens these safety net hospitals and their ability to respond to MCIs should they occur.

As the only Level I Trauma Center and largest emergency department in the east metro, Regions is uniquely positioned to coordinate emergency medical services for the upcoming Republican National Convention. Preparations at Regions have been underway for more than a year with collaboration among departments internally and partnerships forming externally with hospitals, first responders, police, fire and other local entities. For our part, Regions expects to see as many as 300 patients a day in its emergency department during the RNC, up from 150 from what is considered normal activity. We will markedly increase staffing and equipment to accommodate this heightened demand.

Should our community be faced with an MCI, Regions and the other hospitals in the area will respond, as we do now, and care for whoever comes to our doors. We must ensure that the ability to respond to this need never disappears from our community by keeping our hospitals healthy and vibrant.

Regards,

Ralph Frascone, M.D.
Medical director, Emergency Medical Services
Senior physician, Emergency Center
Regions Hospital
Phone: 651-778-0398

Hennepin County Medical Center response to Surge Capacity Snapshot

Prepared: May 6, 2008

Hennepin County Medical Center encourages caution when interpreting the information contained in the Snapshot of Emergency Surge Capacity in Minneapolis. This report assesses daily operating capacity, but does take into account the surge capacity and capability that has been developed in the metro area. The progress has been significant and the system performed well when tested recently by a community event. This level of preparedness, however, is only possible with continued funding and, as the Snapshot report concludes, would be in jeopardy if federal funding is reduced.

Hennepin County Medical Center worked with 28 other metro hospitals to develop a comprehensive surge capacity plan that has been tested as recently as August 1, 2007, when the I35W Bridge collapsed.

At the time of the collapse, three ICU beds were available at Hennepin County Medical Center. Within 45 minutes, by putting the surge capacity plan into action, Hennepin was able to make 25 ICU beds available and the Emergency Department was able to open two thirds of its capacity.

Similar plans are in place at other Twin Cities hospitals that would produce 2500 – 3500 surge beds, with appropriate equipment, able to take patients in the event of a disaster. A community surge plan, including opening an offsite care facility, is also in place and has been exercised.

Continued funding at the current level, or even additional funding, would ensure that the system in Minnesota stays strong. All hospitals today are forced to operate at or near daily capacity. Hospitals are not able to "over staff" for disasters on a daily basis.

Think of it like a rubber band. More funding means a thicker rubber band (hospital emergency system) better able to stretch to respond to disasters. Less funding means a thinner, more brittle rubber band less able to stretch to respond to emergencies.

For more information, contact:
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I 35W Bridge Collapse Emergency Response Summary

Narrative summary

On Aug. 1, the 8-lane, 2000 foot I 35W interstate highway bridge collapsed into the Mississippi causing multiple injuries and deaths.

Hennepin County Medical Center's response and the performance of other hospitals and first responders validated resources put into careful and continual emergency planning and exercising that Hennepin County Medical Center has been leading for many years.

Hennepin County Medical Center is the Regional Hospital Resource Center for 29 hospitals in the 7-county metro area. Upon confirming the information from the first 911 call, the Medical Resource Control Center in the hospital's EMS dispatch center activated the web-based MN-Trak system to notify other hospitals and first responders and coordinate resources on a metro-wide basis.

Within two minutes of the initial reports from the dispatch center, Hennepin's lead emergency room physician declared an "Alert Orange" at the hospital, which activated our emergency operations plan throughout the institution.

Next steps included:
- creating room for patients by opening beds in the emergency department
- opening the Emergency Operations Center to manage hospital operations
- opening a labor pool to make staff available throughout the hospital

In short order we had:
- adequate physician, nursing, and support staff available throughout the hospital
- 10 operating rooms staffed and ready to go
- 3 CT scanners staffed and ready to go
- 25 open ICU beds ready for patients

Hennepin County Medical Center received 25 patients that night from the collapse. Six required emergent intubation.

EMS dispatch center coordinated ambulance response and all patients were transported from that very unstable scene to Hennepin and other hospitals in approximately two hours. Hennepin EMS also continued to provide full service coverage to the rest of its primary service area without "giving away" any calls throughout the night.

Other hospital operational responses:
- the Security Department locked down the buildings to control access to provide privacy for victims and their families and officers also provided increased patrol coverage and service
- Social Services, Chaplaincy, and other departments opened a family support area to provide comfort and information to families of victims and to those looking for family-members that evening
- physician leaders and the Public Relations department provided external communications to the large number of media that showed up instantly and transmitted information live around the world throughout the evening and for the next few days
- support departments including Facilities Management, Environmental Services, Information Technology, and many others responded to the immediate needs as a result of the incident and in the days following
- Critical Incident Stress Management services were provided to staff directly involved in the incident and other support services were made available to staff in the hours and days following the incident.

After-action information
Including patients who walked in for care over the next two days with injuries from the collapse, we received **31** patients from the incident. Metro hospitals treated a total of **126** victims from the event.

We have received, and continue to receive, an outpouring of support and recognition from the community in response to our work that night. From offers of food and volunteers, to posters from kids that say thanks, to mentions in editorials and letters to the editor, it has been gratifying to see that our response, and the work and resources that made such a response possible, are understood and valued by the community.

Media coverage was intense, both during and after the event. According to Nielsen research, TV stories and interviews that mention or include Hennepin County Medical were seen by 62-million people through last Friday. That does not include print, radio, or Internet coverage.

Chairman WAXMAN. The gentlelady's time has expired.

Mr. Sali.

Mr. SALI. Thank you, Mr. Chairman.

Secretary Chertoff, border security is an important issue affecting Idahoans, and the need for secure travel documents I think they consider equally as important. Do you have any security concerns specifically with the use of matricula consular cards, passport cards, NEXUS and Sentry and PASS cards?

Secretary CHERTOFF. First, Mr. Chairman, I guess I do have to observe when I was invited here, I thought the topic was going to be medical surge. It is hard for me to see the correlation here, so I have to ask you whether you want me to answer this. But if you do, I will go ahead and answer.

Chairman WAXMAN. Well, the rules allow each Member to ask questions.

Secretary CHERTOFF. On any topic.

Well, the short answer is I think certainly our NEXUS cards and Sentry cards, our PASS cards which are about to be issued by the Department of State are secure. They reflect a substantial step forward in improving the security of our documentation. Likewise our laser border-crossing cards.

The matricula consular is not an American-issued card, so I can't warrant or vouch for the security of that. We don't rely upon that for purposes of allowing people to come across the border.

Mr. SALI. I think there is a relation here. I hear concerns for many areas of the country that part of the problem in hospitals is that they are overrun with illegal aliens in specific places. And part of the problem in dealing with the problem of illegal aliens is making sure that we have legal ways for people come to our countries that are secure in fact.

Was there a recall on the NEXUS, Sentry or PASS cards during the last year or two?

Secretary CHERTOFF. Not that I am aware of.

Chairman WAXMAN. Mr. Sali, it is your time to ask questions, but you are off the topic for which we have invited the Secretaries to speak, I guess Secretary Chertoff will have to decide whether he is prepared to respond. But——

Mr. SALI. Well, Mr. Chairman——

Secretary CHERTOFF. I could find out. I didn't come prepared to talk about it.

Mr. SALI. Perhaps the Secretary would be willing to respond to some of these questions in writing——

Secretary CHERTOFF. Sure.

Mr. SALI [continuing]. If I submit them to the committee.

[The information referred to follows:]

BILL SALI
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The Honorable Michael Chertoff
Secretary
United States Department of Homeland Security
Washington, DC 20528

Dear Secretary Chertoff:

Thank you for your testimony and participation at the Committee on Oversight and Government Reform's May 7, 2008 hearing, "The Lack of Hospital Emergency Surge Capacity: Will the Administration's Medicaid Regulations Make It Worse?"

Pursuant to our dialog during the hearing, let me ask that you answer the following questions for the official hearing record:

1) Border security is an important issue affecting Idahoans and the need for secure travel documents is paramount.

    a) Does the Department of Homeland Security (DHS) have any concerns specifically with the use of the Matricula Consular card, Passport card, and the Nexus, Sentri and FAST cards?

    b) If so, what specific security concerns does the DHS have and what is the Department doing to rectify its concerns with these travel identification cards?

2) As you know, I signed onto a bipartisan letter dated April 25 that was sent to Secretary Rice and you regarding the security of Western Hemisphere Travel Initiative travel documents. Part of that letter addresses the security of the Passport card and the Nexus, Sentri, and FAST cards among other things.

    a) Were the Nexus, Sentri, and FAST cards ever recalled last year?

        i. If so, what prompted the U.S. Customs and Border Protection to issue a recall of these cards?

    b) Are the Passport cards ready for distribution?

c) If not, what is the reason for the delay in not issuing these cards?

d) Does the current Passport card have any key electronic components made overseas?

e) What countries are involved in the manufacture and assembly of the key components used in the Passport card?

3) Many Idahoans have expressed concern that a proposed Mexican consulate in Boise will foster the continued presence of illegal aliens there.

a) Do the facts support that the Matricula Consular cards, as issued by Mexican consulates in the United States, present national security concerns?

i. If so, what are the Department of Homeland Security's national security concerns with the Matricula Consular cards?

b) Are you aware of any situations where illegal aliens gain access to government programs, banking, housing, and health care benefits with the Matricula Consular card?

i. If so, could you please provide details of when illegal aliens used Matricula Consular cards to obtain government benefits?

Please provide my office with your responses no later than 30 days. If you have any questions regarding this letter, please contact Rick Podliska at (202) 225-6611.

Sincerely,

Bill Sali
Member of Congress

Mr. SALI. And if I may continue, do you share the concern that the presence of illegal aliens in our country is affecting the ability of our hospitals to respond in a surge situation?

Secretary CHERTOFF. Well, I don't know if I would connect it to a surge, but I would agree that I am aware that the presence of people who are in this country illegally does strain emergency rooms on a day-to-day basis, because often these people don't have health care through their employers, so they are relying on the emergency room as a kind of primary care facility. And that is one of the things we hoped to address when we took up the issue of comprehensive immigration reform, but as everybody now knows, that didn't take off in the Senate. So in the meantime our approach is to enforce the existing laws as vigorously as possible.

Mr. SALI. Secretary Leavitt, let me ask you the same question. Do you share that concern about the presence of illegal aliens, overwhelming at times, on the emergency room and hospital capabilities in our country, and if you do, what is your office doing to relieve that situation?

Secretary LEAVITT. Again, there is no connection necessarily between surge capacity. But there is little question that many of those who go to emergency rooms to be treated are here without proper documentation. Our Department does provide substantial assistance to hospitals to pay for those, but there is no question about the fact that it is a big part of the problem.

Mr. SALI. How much does your agency pay for treatment for illegal aliens each year?

Secretary LEAVITT. That is not a number I have off the top of my head. It is a big number.

Mr. SALI. You will get that for me, though?

Secretary LEAVITT. I would be happy to respond in writing, to the degree we have that information.

Mr. SALI. I have heard both of you say today that the presence of illegal aliens is not directly related to the surge, and yet both of you have said that illegal aliens use emergency rooms as their primary care doorway, if you will, into the health-care system.

Secretary LEAVITT. This is an important point, and I want to clarify it. On a day-to-day basis, in an emergency room, there are many people who are there for what essentially could be a clinic, not necessarily an emergency. In such a setting, they would be asked to take their health-care problem or defer it for another time, and that capacity would be used for the surge. Virtually any emergency room would have somewhere between 30 to 50 percent of its capacity used in that way.

So when we say that they are overflowing, they are not overflowing necessarily with people who are in life-and-death situations. Surge capacity would clear those out in the kind of emergency we are talking about to be treated in another way or on a different day.

Chairman WAXMAN. The gentleman's time has expired.

Mr. Sarbanes.

Mr. SARBANES. Thank you, Mr. Chairman.

On that last point, we had testimony on Monday that suggested that a relatively small percentage of the ED volume is from nonurgent kinds of care. So I think that is a red herring. We are really

talking about people coming into emergency rooms that need emergency care.

We had a number of hearings on the effect of these Medicaid regulations. Going back last year, in June, we were told by a panel of experts that the emergency rooms are at the breaking point and the ability of emergency department personnel to respond to a public health disaster is in severe peril.

In November, the American College of Emergency Physicians said that if the regulations we are discussing today went into effect, "The Nation's public hospitals and emergency departments will sustain a devastating fiscal blow from which recovery may be impossible."

And the National Association of Public hospitals—and, by the way, public hospitals are the ones really getting hit between the eyes. We had a description of a nonprofit hospital engaged in some purchases, which I am not sure I would necessarily defend myself, but let's not get off on that tangent. We are talking about the impact largely on public hospitals, which are the ones that would suffer the most from implementation of this regulation. The Association of Public Hospitals said, "These regulations have the potential to devastate essential safety-net hospitals and health systems in many parts of the country."

So what is it that these experts understand that the two of you don't understand about the impact these regulations are going to have?

Secretary LEAVITT. Mr. Sarbanes, let me describe for you, as a former Governor, what is happening with respect to public hospitals and where I believe we ought to be turning to remedy this.

It is not unusual at all, in our public hospital setting, we agree to pay public hospitals an increment more than what we do normal hospitals. Many States are taking that increment more and essentially taking it off the table, putting it into their general revenues, and then using that increment more to pay the match that they are supposed to be paying for Medicaid.

This is essentially a dispute between partners. We are saying to the States, we want you to put up real dollars, not our dollars recycled, so that you don't have to put up as much money.

Mr. SARBANES. Let me take that line of thinking and move it slightly in a different direction.

First of all, I want to challenge a premise that I thought I heard in your testimony, that perhaps hospitals are not at the center of any kind of disaster response. And you talk about these other things, convention centers being set up on a short-term basis or schools or so forth.

But you both agree that when there is an emergency or a disaster, hospital emergency rooms are where people go, are they not?

I mean, I represented hospitals for 16 years. Any kind of disaster or occurrence in the community that created pressure, the first place they come, the first place they come, because they can't think of any other place to go, is to the emergency room. True?

Secretary LEAVITT. Mr. Sarbanes, there is no hospital in America that can keep enough spare capacity warm all the time just in case we have a major catastrophic event.

Mr. SARBANES. Let me ask you this question.

Secretary LEAVITT. You can develop a scenario that will blow the doors off any emergency room in America——

Mr. SARBANES. The doors are already blown off. This is the thing. There is this notion that we are waiting for these surge situations. But as a practical matter, we have a surge already. When you look at the boarding that is going on, the diversions that are going on, the fact that the beds in the hospitals for inpatient admissions are completely full, we are talking about a surge happening right now.

Now, let me ask you this question: If a hospital is underfunded, understaffed and underequipped in its main operations and main functions, is it better or less prepared for a surge, in your view?

Secretary LEAVITT. This question ought to be directed to those who administer and invest in the hospital. Most of the hospitals——

Mr. SARBANES. I am just asking your personal opinion. If a hospital in its core function is underfunded, underequipped and understaffed, is it better or less prepared for an emergency in a surge?

Secretary LEAVITT. Obviously they are less prepared.

Mr. SARBANES. They are less prepared. Well, that is the situation many of the hospitals are in.

So this fascinating but, I think, largely false distinction between funding that is going just for a surge as opposed to funding that is going to what Medicaid core functions should be, this is a red herring, at best.

And we have to strengthen the underlying core function and structure and infrastructure of our public hospital system and other parts of our health-care system if we are going to be able to respond to this surge.

Thank you.

Chairman WAXMAN. And we shouldn't be cutting money out of it if they are already not prepared to deal with the problems.

Mr. Issa, you are recognized.

Mr. ISSA. Well, thank you, Mr. Chairman.

And I certainly think that it has been good to wait a little while to go today, because I think Mr. Sali's questions, although they seemed to start on a tangent, finished pretty cogently.

Secretary Chertoff, the link that you did agree exists between our inability to either stop illegal immigration or the absence of their having an alternate insurance plan that would put them into the normal front-door of hospital and urgent care and other places rather than emergency rooms and trauma centers is a significant part of the overcrowding and the underfunding today.

From your side, Homeland Security, you seem to very much agree that is part of the problem you face when looking at surge capacity today, is can you get those centers freed up in time of emergency.

So my question to you is, do you feel comfortable that even though a nonscientific, partisan telephone survey found that, lo and behold, these seven trauma centers were overcrowded on a given day, or emergency rooms, that those would be reasonably free-upable for the kind of catastrophic emergencies we might have in the case of a dirty bomb or some other terrorist attack?

Secretary CHERTOFF. Well, I agree with Secretary Leavitt. My understanding—of course, the expertise really resides with his De-

partment, but it certainly makes sense to me. My understanding is that, in a true emergency, people who are in the emergency room using it for primary care or for something less than an emergency would be asked to leave, and many of them would.

I also agree with Secretary Levitt there is probably some point at which no emergency center, no matter how well-funded, is going to be able to handle what would be a truly mass event. And that is why we have these backup systems in place.

There is no question that a catastrophic event is going to be bad. It is not going to be pleasant. But I think that we would expect the emergency room to clear out all but the priority cases in order to handle them.

Mr. ISSA. I certainly agree. And certainly there are doctors who have been serving in capacities other than urgent care whose experience in surgery and other areas would quickly be brought in post-triage to do it.

Governor Leavitt, you know, the title of this hearing today I think is significant, because it starts off and it says, "The Lack of Hospital Emergency Surge Capacity: Will the Administration Medicare Regulations Make It Worse?"

Yesterday, or the day before yesterday, I asked the panel—who all felt that overcrowding was a problem and so on but differed on whether they could handle emergencies. Virginia said, "We did handle emergencies. We believe we are well-organized, even here in the District," while other areas did not.

One of the interesting things was, I said, "Here is a billion dollars. How would you spend it? Would you spend it on training and preparation for an emergency, or how else would you spend it?" To a person, the panel said, "I would spend it on day-to-day, routine costs. I would simply absorb a billion dollars."

Governor, certainly you have the background to understand that $1 billion is a lot of money. But the cost of injuries in America today is estimated to be $300 billion in medical costs. A billion, $2 billion, $3 billion, if it is not used for preparation training, emergency facilities and planning, even $3 billion or $4 billion added into the system, will it in fact increase surge capacity if it is simply spent on a daily basis?

Secretary LEAVITT. Our significant concern with moneys that we give to States is that they are focused on increasing surge capacity. We have put nearly $7 billion, through different departments other than Medicaid, into emergency preparedness and specifically into surge capacity. And I believe that if we were just to send Medicaid money, it would be absorbed into the hospital overhead.

Mr. ISSA. And, Governor, following up, because the time is limited, essentially aren't we dealing exactly with that here today? That if, in fact, we don't carefully make sure that these funds do not get diverted and do not cover up for problems, including illegal immigration, to quote the other Member, but all kinds of problems of the underinsured, aren't we, by definition, making ourselves less capable if we don't take action to ensure that it goes into planning and training and preparation, rather than absorbing what clearly appears to be an everyday problem in America that was neither created by September 11th nor would be rectified by a few billion more dollars here or there?

Secretary LEAVITT. Every community needs a plan, every community needs to train, every community needs to exercise. And that is what much of our money goes to, and should.

Mr. ISSA. Governor, my time is short, but you did deal with the problems of illegal immigration. You dealt with the problem of your emergency rooms and the impact of the underinsured.

Isn't that a separate issue that we should concentrate on finding solutions for but not mix it with today's hearing on surge capacity directly related to 9/11-type events?

Secretary LEAVITT. We have dealt with three specific and different issues today: surge capacity, the effect of illegal immigration, and Medicaid regulations. All three are separate. All three are important issues.

Mr. ISSA. Thank you.

Thank you, Mr. Chairman.

Chairman WAXMAN. Secretary Leavitt, could you furnish for the record how that $7 billion you claimed is going to help the hospitals?

Secretary LEAVITT. What I said, Mr. Chairman, was we have spent nearly $7 billion on local and emergency preparedness, including surge capacity in hospitals. And, certainly, we can provide how that has been spent.

Chairman WAXMAN. And how much of that has been surge capacity?

Secretary LEAVITT. That is not a figure I have.

Chairman WAXMAN. If you could give it to us for the record, we would appreciate it.

We now have Mr. Murphy.

Mr. MURPHY. Thank you very much, Mr. Chairman.

Welcome, Secretary Leavitt and Secretary Chertoff.

For the last 4 years, before I came to Congress, I was the chairman of Connecticut's Public Health Committee in our legislature charged with this very issue, making sure that we had appropriate surge capacity and everyday capacity in our hospitals.

And, Mr. Leavitt, I was reading through your testimony, and it is dazzling, at some level, the amount of bureaucracy and commissions that we have created around this issue: ACD, NVSB, ECCC, ASPR, NRF. And I am sure these are worthy commissions; I am sure they are looking at important questions. But as somebody who is doing this on the ground floor, this is all new to me.

As a State policymaker, we knew that Medicaid was not just about supporting people, it was about supporting institutions as well. They are one and the same. You can't help people unless you have institutions that are there and willing to do the work. So the distinction, I guess, is a little bit troubling to me.

But we also didn't know too much about these grants that were coming to us, because we really knew that in order to keep these hospitals up and running, in order to keep capacity working, we needed Medicaid. We couldn't do it with grants alone.

Mr. Leavitt and Mr. Chertoff, if the staff has it ready, I would like to just draw your attention to a chart. And this, I think, gets at Chairman Waxman's question about the amount of money that is going to hospital preparedness grants. This is, I think, a fair representation of, over the last several years, the amount of money

that has been going into hospital preparedness grants, starting at $498 million in 2003, dropping now to a proposed $362 million in the proposed budget for the coming fiscal year—a pretty sharp decrease. And $362 million over 50 States spreads pretty thin.

The real rub here is when you compare it to the Medicaid cuts, if we can put that chart up now. Now, this is the grant money that States are getting, $362 million proposed in the next year, compared to the impact of the Medicaid cuts.

Now, this is the State Medicaid director's estimates. If you take the CBO estimates, you are still talking about five times the amount of Medicaid cuts as you are talking in grant money to hospitals. And I think every State appreciates that grant money, but it is a drop in the bucket compared to what hospitals are going to face with regard to these Medicaid cuts.

I guess I ask this to you, Secretary Leavitt. Do you have concerns that these grants, dwindling year by year, are going to be dwarfed by the size of these cuts? And though those cuts are going to obviously see their way through the entirety of a hospital's operation, no doubt much of it is going to end up in the emergency room.

Do you have a concern that these cuts, these Medicaid cuts—you say they are to support individuals; they inevitably have to support institutions in order to support the individuals—are going to dwarf those grants?

Secretary LEAVITT. Mr. Murphy, the distinction on institutions and people is not one that we have arbitrarily made. It is in the statute.

Over time, States have inappropriately claimed Medicaid dollars in a number of categories, which had the direct impact—I know you know this as a State legislator—of crowding out all of the other activities, including the development of public health and emergency systems.

Medicaid was not designed, nor is it intended, to support institutions. Money should be directed to people. We support people. We support poor people, pregnant mothers and the disabled. This is not intended to be a hospital entitlement.

Now, I understand that they have come to rely on it, in some cases. That is precisely the reason that we are pushing back to the fee-based consultants who are driving this on the basis of their getting a piece of the action to push Medicaid into every area of State government. It is not just emergency preparedness. It is in schools. It is in child welfare. It is in all the places that the States are not adequately funding, they are trying to get a garden hose into the Medicaid fund.

Mr. MURPHY. But we are not talking about those places today. We are talking about institutions that are indisputably linked to health care, which are hospitals.

And the fact is you say it is about supporting individuals, but the money doesn't go to individuals. It goes to institutions. It goes to doctors. It goes to hospitals. It goes to outpatient clinics. Because we know we need those places up and running.

So let me just shift to a related question, and this is building off of Mr. Sarbanes's questions.

You talk about the fact that ultimately this isn't going to happen in emergency rooms. If something enormous happens, you are

going to have to build something outside of the emergency room. But doesn't that capacity, whether it exists in the physical confines of the emergency room or not, rely on the assets that exist right now in those emergency rooms?

If we are gutting the capacity of hospital emergency delivery systems, in terms of equipment, in terms of personnel, in terms of expertise, it seems to me, Mr. Leavitt and Mr. Chertoff, that this directly impacts your ability to then move that capacity offsite, even if it isn't onsite at the hospital grounds.

Secretary LEAVITT. Again, this is a very important point, Mr. Murphy. We are bringing capacity in. In the first 24 hours of an emergency, we are dependent upon local assets. And that is where you clear out the emergency room, you take anyone who is nonessential out of the hospital. You make capacity.

Within 24 hours, we have the NDMS system there. We have as many as 6,000 beds we can bring from all over the country. We then go to another phase where we start taking patients into capacity. At any given moment, we know how many hospital beds are available in the area.

We are not dependent upon the hospital facilities, except for that 24-hour period. And that is why we exercise and train for all of the other aspects on surge capacity.

Mr. MURPHY. And I appreciate that. I know enough about how these things work to know that they still do draw upon local resources, they still do draw upon other hospitals, upon other capacity in the system. And, as Mr. Sarbanes and others have suggested here today, we have maxed out both the emergency and nonemergency capacity of our health-care systems to the point that extra capacity, even in the 48 and 72-hour window, simply doesn't exist.

Now, you can fly it from in from all over the country, but I think this problem exists across the board. Our medical technicians, our emergency medical personnel, are working 24/7 just to handle existing capacity right now, never mind being able to move over to an emergency when it does happen.

My time has expired, Mr. Chairman.

Chairman WAXMAN. Thank you, Mr. Murphy.

Mr. Duncan.

Mr. DUNCAN. Thank you, Mr. Chairman.

Secretary Leavitt, I have to be very quick because they have a vote going on. But a few days ago, we were given figures that, in the 10 years leading up to 2006, Medicaid payments to Tennessee hospitals went up from $245 million to $607 million.

I am sure that you have no idea of what those exact figures are, but do you think that every State has received similar-type increases, more than doubling over the last 10 years?

Secretary LEAVITT. Well, States have clearly seen dramatic increases. We have seen a dramatic increase in the overall program. Tennessee may have been somewhat unique because of TennCare.

Mr. DUNCAN. And would it be fair, then, to say that, in those 10 years, inflation has averaged around 3 percent a year, so those payments to hospitals have gone up several times above the rate of inflation? Do you think that is fair?

Secretary LEAVITT. Medicaid is growing at two to three times inflation.

Mr. DUNCAN. Two to three times the rate of inflation. So payments to the hospitals have gone way up over the past 10 years?

Secretary LEAVITT. The Medicaid money going to hospitals has dramatically increased over the past decade.

Mr. DUNCAN. All right. Thank you very much.

Chairman WAXMAN. Mr. Tierney.

Mr. TIERNEY. Thank you, Mr. Chairman.

Thank you, gentlemen, for being here today.

Secretary Chertoff, I want to ask you a little bit about your role or your involvement in these Medicaid rules that were issued. In your testimony, you said that, "Medical surge capacity is a critical element of our local, State and national resiliency."

But I don't see any evidence, I don't think we have been able to find any evidence of your Department expressing any concern about these Medicaid rules to anybody, and particularly with respect to the impact they might have on emergency rooms or the ability to respond to an attack or a natural disaster.

Did you consult with Secretary Leavitt about these rules before they were issued?

Secretary CHERTOFF. No, because I don't think that these Medicaid rules are particularly closely connected to the question of whether there is surge capacity necessary to meet an emergency.

Mr. TIERNEY. So you were aware of them but just chose not to get involved, or you weren't even aware that they were being considered?

Secretary CHERTOFF. I don't think I was particularly aware of it, nor would I have expected to be made aware of it.

Mr. TIERNEY. The staff interviewed Dr. Runge from your staff, your Chief Medical Officer. It is his role, apparently, to coordinate between the Department of Health and Human Services, to make sure that hospitals and the medical system are prepared for a disaster or for an incident.

They asked Dr. Runge if he had reviewed or commented on the regulations, and he also said he had no communications with anyone at HHS about it. And he said that there was no discussion within the Department of Homeland Security about the rules.

That is pretty consistent with your testimony, as well, on that?

Secretary CHERTOFF. It is.

Mr. TIERNEY. If he supposed to be the point person for medical preparedness, I just don't understand how he completely ignores rules which are certainly going to have some impact? Or is it your position they are absolutely going to have no impact at all on emergency rooms?

Secretary CHERTOFF. Here is where I think we are having some disagreement. Everything has impact on everything. So, in some sense, the economic health of the country has an impact on homeland security. But if I used that logic, I would be involved also in the subprime mortgage crisis, because that affects State budgets; I would be involved in gas tax and gasoline prices, because that has an impact. Even for a Department which has sometimes been accused of having too broad mandate, that goes several bridges too far.

Our focus, with respect to working with HHS, is to assure that there is a planning effort under way, that we are identifying gaps, and that we are coming up with specific measures that will plug the gaps.

And I have to say I agree with Secretary Leavitt; I don't think that Medicaid funding and reimbursement rules have anything more than a very indirect connection with this issue. And if I took the position that every indirect impact on homeland security made it my business, we would become the Office of Management and Budget instead of the Department of Homeland Security.

Mr. TIERNEY. I do think there is a disconnect between what we are talking about here. I have a difficult time thinking that you don't see a more direct relationship between the status of our hospitals' capacity and emergency rooms' capacity to deal with these things than a mortgage. That is a bit of a difference there between the two, and I would hope you would get that distinction.

Secretary CHERTOFF. No, I don't say that I don't think emergency care and the health-care system isn't more connected. I think that Medicaid reimbursement, which is not specifically targeted to putting money away for emergencies, is, I think, several degrees of separation from the kinds of much more specific issues that we are focused on, in terms of getting ready for emergencies.

Mr. TIERNEY. But I find it interesting that your Department didn't even look at the prospect that reducing Medicaid funding might have an impact on hospitals' overall operations, including the impact on emergency rooms and capacity in case of a surge incident. I would think that is the type of thing that you are assigned to do and Dr. Runge is assigned to do, to at least raise the issue and think about it and move on from there.

The staff asked Dr. Runge how he justified this lack of communication with HHS about the rule. What he said was, "We are focused on threats that can kill hundreds of thousands, not hundreds." A little insensitive, I would think, to——

Secretary CHERTOFF. Well, I wasn't there for the interview; I can't read his mind. But I think what he was trying to draw a distinction between is the very real issue of day-to-day capability of the medical system to deal with day-to-day kinds of issues, which is a perfectly important and significant matter but not one that falls within the purview of my Department, as compared to dealing with the issues that do rise to the level or do specifically involve homeland security, like a pandemic flu or a major catastrophe, where we do focus on the issue of surge.

But our main focus is on those matters that have a direct relationship. Are we stockpiling enough? Do we have a plan? Do we have a delivery mechanism? Do the localities have a plan? And there we do interface with HHS, not only Dr. Runge, but I personally talk to Secretary Leavitt about these issues. But much more tightly related to the specific need to have an emergency preparedness capability than Medicaid funding, which has to do with the overall economic health of the medical system, which is, frankly, a much broader issue than my Department's focus.

Mr. TIERNEY. Well, I guess it could be seen that way, but it could be narrowed down to when there is a serious, severe cut in financing, it will affect the operations of a hospital, including those that

you are directly concerned with. I would like to think your Department gets involved at that capacity. That is not indirect; that is pretty direct.

My time is up, and I yield back. Thank you.

Chairman WAXMAN. The gentleman's time has expired.

Ms. Norton.

Ms. NORTON. Thank you, Mr. Chairman.

I want to thank both these witnesses for being here.

I am particularly grateful for this hearing, because I am afraid I am more deeply implicated than some because of my representation of the District of Columbia. I have worked closely, of course, in my work on the Homeland Security Committee with Secretary Chertoff.

Secretary Leavitt, I worked with your predecessor on something called ER–1. I am particularly concerned about this place, not only because I represent 600,000 people here, but because all of official Washington is here, 200,000 Federal workers, and because this is a prime target for terrorism.

This discussion about trying to separate out Medicaid from other money is important because we want money used for what it is intended. But you certainly can't treat a hospital as if it were not an organism with core functions that treat private and poor patients alike, as if you could collapse the part that treats Medicaid patients. And I think that is what some of us have been trying to get at.

I want to ask you about the hospitals here. We have three trauma centers here. Two of them were surveyed in this survey, and they were extensively above capacity. No available treatment spaces in the hospital. Only six had intensive care unit beds. One could not participate in the survey because it was so overcrowded that it had to stop taking, accepting new patients at all.

My good friends on the other side of this dais cite the Washington Hospital Center emergency room as a model for the country. It is a very good emergency room. That is what I worked with on so-called ER–1. I will get to that in a minute.

But since they cite the Washington Hospital Center, I went to the head of the emergency room, Dr. Mark Smith, and Dr. Smith confirmed the findings of the survey and, in addition, said he had twice as many patients as he did treatment spaces. They are putting them in the corridors and administrative offices. They are putting them in waiting rooms. And he said he had a major problem with preparedness.

Now, I understand triage. I also hope we are not ever in the position of what I would believe would be chaotic triage, if everybody surged in one place. For that reason, here in the Nation's Capital, I have been working with the administration—actually we have almost gotten it through several times—on at least one hospital that would have surge capacity, so that everybody would know in advance, don't put all these Federal workers close to the nearest hospital. This is the one that is prepared. It has huge capacity—it would have a huge capacity. A lot of private money would go into this, some Federal money.

Now, my question is this: If you cut billions of dollars of what amounts to safety-net funding from hospitals, you are also includ-

ing these trauma centers here in the Nation's Capital. Can you assure this committee that, even with such very severe Medicaid cuts, the hospitals in the Nation's Capital are prepared for a mass event here and to accept patients in the event of a mass event here?

I would further ask Secretary Leavitt if he supports ER–1.

First, I want to know, are you saying to this committee, in the face of a survey that you are aware of, that in the event of a major or mass event here, that the hospitals, even with the cuts that are on the table, could, in fact, manage that event?

Secretary LEAVITT. Ms. Norton, I will tell you that the Washington, DC, area engages in regular planning exercises I think as well as any place in the country. I want to restate: Am I saying that surge capacity is acceptable everywhere in the country? No.

Ms. NORTON. I am not asking about that. I am asking about the place where Members of Congress, the President of the United States, where members of the Cabinet, where 600,000 residents are here, where 200,000 workers are here, three traumas centers—I am being very specific. I am not focusing on elsewhere. I am focusing on target No. 1.

Can you say you are prepared?

Secretary LEAVITT. I am not the person to answer that. The person in my Department would be Rear Admiral Vanderwagen, who was not invited to the hearing today. And I am sure he would be happy to meet with you and give you his reaction to the preparedness.

Ms. NORTON. I have to indicate that, as the Secretary, I would think you would know whether or not the Nation's Capital is prepared for a mass event.

Secretary LEAVITT. I live here, just like you do, and I am anxious for that to be the case.

Ms. NORTON. And that troubles me, both as a member of the Homeland Security Committee and as a member of this committee, that you cannot answer that question.

Do you support ER–1 surge capacity?

Secretary LEAVITT. Is the project at George Washington?

Ms. NORTON. It is the project at Washington Medical Center.

Secretary LEAVITT. I am aware of the project by title. I do not know enough about it to respond at this hearing. If you would like, I would be pleased to respond in writing.

Ms. NORTON. I very much appreciate it.

And thank you, Mr. Chairman.

Chairman WAXMAN. Thank you, Ms. Norton.

Mr. Cummings.

Mr. CUMMINGS. Thank you very much, Mr. Chairman.

Secretary Leavitt, perhaps the thing that most confuses me about your actions is why you did not consider the impact of your Medicaid regulations on emergency preparedness.

Last June, the committee had a hearing on the state of emergency medical care in the United States. At the hearing, concerns were raised about the effect of the Medicaid regulations on hospital emergency rooms. As a result, the committee wrote to the Centers for Medicare and Medicaid Services to ask whether CMS, which issued the rules, had consulted with the Assistant Secretary for

Preparedness, who is the official in your Department in charge of emergency response.

Astonishingly and unbelievably, CMS responded that it, "did not specifically request input from the Office of the Assistant Secretary for Preparedness because that office is not likely to have expertise in Medicaid financing."

The committee wrote you again in November. In this letter the committee specifically requested, "all documents relating to the potential impact of the Medicaid regulations on emergency care and trama services." In February, the Department responded to the committee's request. I want to read to you from this letter. And it says, "The Department has not found responsive documents."

According to this letter, your staff searched for responsive documents in five different parts of the Department: the Office of the Secretary, the Office of the Assistant Secretary for Preparedness, the Health Resources and Services Administration, the Centers for Disease Control, and CMS. Yet not one of those offices had done any analysis of the impact of the regulations on emergency care.

Secretary Leavitt, how can you possibly explain this? Hospitals across the Nation are telling us that your regulations will devastate their emergency rooms, yet you did not even consider this issue, according to what I just read.

Secretary LEAVITT. The rule change we are proposing is not about surge capacity or hospital health. It is about States who have been claiming inappropriately funds that they are using to recirculate to pay their fair share with Federal funds.

Medicaid is not a program to support hospitals. Medicaid is a program to support people who are poor, people who are pregnant and people who are disabled. It was not intended nor is its purpose, nor should it be managed, to be the source of funds for surge capacity.

Mr. CUMMINGS. Let me just go a little bit further. You were specifically asked to consider the impacts of your rules on trauma centers and emergency rooms. Over a year ago, Chairman Waxman and over 150 other Members of Congress wrote to you to urge you to consider these issues.

Let me read to you from our letter: "We are writing to request that you withdraw the proposed rule. The proposal would threaten the capacity of safety-net hospitals to deliver critical but unprofitable services, such as trauma centers, burn units and emergency departments."

Yet, still, you prepared no analysis. This appears to be a case of willful blindness. Perhaps it would be better stated if I said it appears to be "eyes wide shut." It seems that you are deliberately ignoring the impacts that your rules will have on emergency care and preparedness in our Nation. That is irresponsible, and, to be frank with you, it is quite dangerous.

Secretary Leavitt, the preamble to the proposed Medicaid regulations read, "With respect to clinical care, we anticipate this rule's effect on actual patient services to be minimal. While States may need to change reimbursement or financing methods, we do not anticipate that the services delivered by governmentally operated providers or private providers will change."

In response to these regulations, your Department received over 400 written comments, all of which expressed opposition to the rule or to portions of the rule. And I would like to read just a sample of one of those. It is from the Society of Academic Emergency Medicine.

And it says, "This proposal will jeopardize the viability of public and other safety-net hospitals. It will also jeopardize the viability of our emergency medicine teaching programs, which has long-reaching downstream effects on the quality of emergency care in this country. We believe that Medicaid cuts of this magnitude projected under this proposed rule will adversely affect access and the viability of our Nation's safety-net providers."

So I am just wondering, do you have a comment on that?

Secretary LEAVITT. Yes, I do. This rule is about States not paying their fair share, and it is a dispute between partners. We are mutually committed. If States will step up and do their share, we will ours. But this is about paying for people, not for institutions.

We are following the law. We are trying to push back where people or States and other programs within State governments are trying to make up for deficiencies that have occurred in State governments by tapping Medicaid funds. And someone needs to do it, because the Medicaid program is unsustainable in its current course; I made the point earlier.

Many of the programs in States are being crowded out by Medicaid. And it is being crowded out because we continue to use it for virtually every aspect of State government. Anyone in State government who thinks they can find some connection to Medicaid is attempting it. And we have to do this in a way to keep the integrity of the fund, so that we know we are paying for health care for people, not for institutions, and we are not making up for States who aren't doing their share.

Mr. CUMMINGS. I see my time is up.

Chairman WAXMAN. Secretary Leavitt, with all due respect, I think you are ignoring reality. You are saying that you want to cut back on a system that is getting Federal dollars inappropriately, and they should make up the money at the State and local level. They are not going to be able to make up that money in a recession. The income is not coming into the States.

And you never asked your partners, the States, what the impact would be to make these kinds of withdrawals of the Federal share of the Medicaid funds that go to the institutions, especially public hospitals that are funded exclusive by the taxpayers. At the minimum, I would have thought that you would have wanted to ask the question of what the impact would be, so you would know.

You insist that is not going to have this kind of impact. Yet, when you put our rules, the Society for Academic Emergency Medicine said, "This proposal will jeopardize the viability of public and other safety-net hospitals. It will jeopardize the viability of our emergency medicine teaching programs."

Parkland Hospital in Texas said they received Medicaid payments of $90 million annually and that, without this funding, Parkland may be forced to drastically scale back their services in the Trauma I center, the level Trauma I center.

You have all these others—the president of the University of California, the University of California academic medical centers. You have all these comments. And we looked at the rulemaking record; the fact is you ignored these comments. You didn't adjust the policy in response to these comments in the final rule, and you did prepare an analysis to the effect of the Medicaid regulations would be minimal impact on care being provided by the States.

How can that be? Isn't that irresponsible?

Secretary LEAVITT. Mr. Chairman, it is responsible for me to follow the law and assure that the States are doing their job. Otherwise, we are not being a wise steward of limited Medicaid funds.

This is a dispute between partners, between the Federal Government and the States. And the Federal Government is saying, you can't take money we have given you extra for these hospitals, put them back into your general fund, and then use them to pay your share. Just give us real money, give us value, give us—for real patients.

This is not about surge capacity. It is about a relationship between the States and the national Government——

Chairman WAXMAN. The consequences will be the institutions that provide the safety net to the very poor in our society will not be able to continue to function and provide those services.

It just seems to me you are judging your actions on an ideology without having established the record. You didn't come to Congress and ask for those changes. You are trying to put them into effect on your own.

Fifty Governors have asked us to at least put a halt on this so they can be studied, which they should have been studied before they were put into place. An overwhelming majority of the House of Representatives has put a hold on these regs until we can look at them further.

I think that you ought to withdraw these regulations and let's see what the impact will be. Let's know that we are not doing any harm to the ability for hospitals around the country to deal with the problems that they may face, not just day to day, but in a terrorist attack.

Secretary LEAVITT. It is not surprising to me that you can unite 50 Governors around the proposition that the Federal Government should pay their share. And that is essentially what this amounts to.

Many States have improperly used money that has come from the Federal Government for the purpose of supporting the hospitals we are talking about, have taken it off the table, and then used it to pay their share.

This is about States not paying their fair share. And I would think we would all be united in saying, if we are going to have a partnership, then everyone out to pay real dollars for real value for real patients.

Chairman WAXMAN. Did you consult with Secretary Chertoff to tell him that there may be some impact around the country on the ability to deal with a terrorist attack?

Secretary LEAVITT. This is a dispute between the Federal Government and the States on Medicaid financing.

Chairman WAXMAN. You didn't inform Secretary Chertoff of that?

Secretary LEAVITT. We regularly consult on the larger strategic issues related to our joint mission. This is not one of them.

Chairman WAXMAN. Did you do an evaluation to know what the impact would be on these hospitals if these regs went into place?

Secretary LEAVITT. Medicaid is not intended to support institutions. It is intended to support people.

Chairman WAXMAN. But it does support these institutions, because people without insurance go to these hospitals. People who are injured go to these hospitals. If you withdraw the money from the hospitals because you have a theory that the States ought to come up with more money, it means, as we were told by Dr. Roger Lewis, who is an emergency room physician at UCLA, a nationally recognized expert in hospital emergency preparedness, he said, "Those of us who work on the front lines of the medical care system believe it is irrational that an emergency care system that is already overwhelmed by the day-to-day volume of acutely ill patients would be able to expand its capacity on short notice in response to a terrorist attack." He said, "If a bomb went off in Los Angeles and injured hundreds or thousands, LA would not have the emergency room capacity to care for the wounded."

In your statement to the Congress, you emphasize the support the Federal Government is giving States and localities to improve this emergency preparedness. And we asked Dr. Lewis, and he said they were getting $433,000 in a preparedness grant, and he was very grateful for it, but the cost of these Medicaid changes would mean they would go without $50 million. He said that is 100 times more than the Medicaid cuts they would get on these preparedness grants, and they are going to be in very, very sad shape.

Do you take what he had to say seriously? Do you think he is just fronting for the States because they want to rejigger their money around?

Secretary LEAVITT. Mr. Chairman, over the course of the last 3 years, I have been in virtually every State and met with the emergency community, and the record is replete with my statements of concern about surge capacity. It is not at the level we want it to be. We have many areas in which we can improve. But Medicaid is not the source of funds to do that.

If the Congress of the United States views that there is a need for more dollars, we have ways in which we can funnel directly to the hospital funds that are necessary to improve their surge capacity.

Medicaid was intended to be for people, not for institutions. And every institution I know would like to drag a garden hose over into the Medicaid fund and be able to tap it, because their fund isn't what they would like it to be.

We need to be disciplined. We need to ensure that these disputes are resolved between the States and the Federal Government so that we have a true partnership, not just one that relies entirely on the Federal Government.

Chairman WAXMAN. Well, I must say, with all due respect, your actions make absolutely no sense. The tiny grants you are giving to hospitals can't possibly offset the impact of cutting billions of dollars from those programs.

I must say, as we conclude this hearing, I find it very discouraging. We know the Nation's emergency rooms are already at the breaking point. We know a terrorist bombing is a predictable surprise. We know that local emergency room capacity is critical to saving lives in that golden hour following an attack. We know that public and teaching hospitals operate many of our Nation's most critical emergency rooms and trauma centers.

We know that the Medicaid regulations will reduce funding to these institutions by hundreds of millions of dollars each year. We know that these cuts will further undermine the ability of these hospitals to respond to a terrorist bombing. We know that these regulations will go into effect in 3 short weeks.

And yet the Secretaries that are in the position to avoid this harm will not take any action. I think it is regrettable.

I must say, this is not just a disagreement. I think it is a substantial breach in what I think is our mutual responsibility to make sure that we can deal with a homeland security attack, which could amount to a tragedy.

I thank you both for being here. We hear the bells; there is a vote on the House floor.

I do want to ask unanimous consent that the record be held open for Members to ask further questions and get responses in writing.

We stand adjourned.

[Whereupon, at 11:15 a.m., the committee was adjourned.]

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